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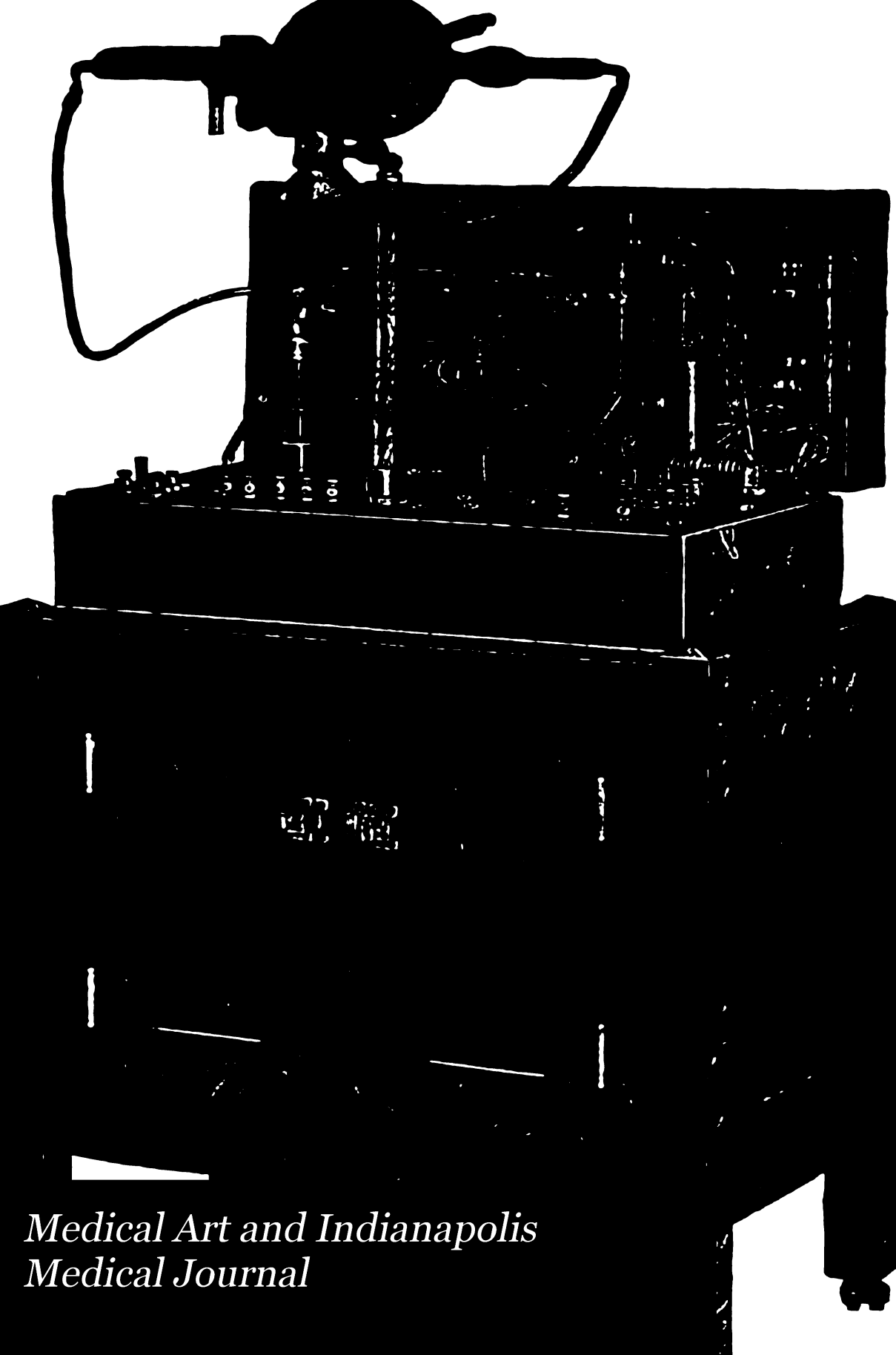

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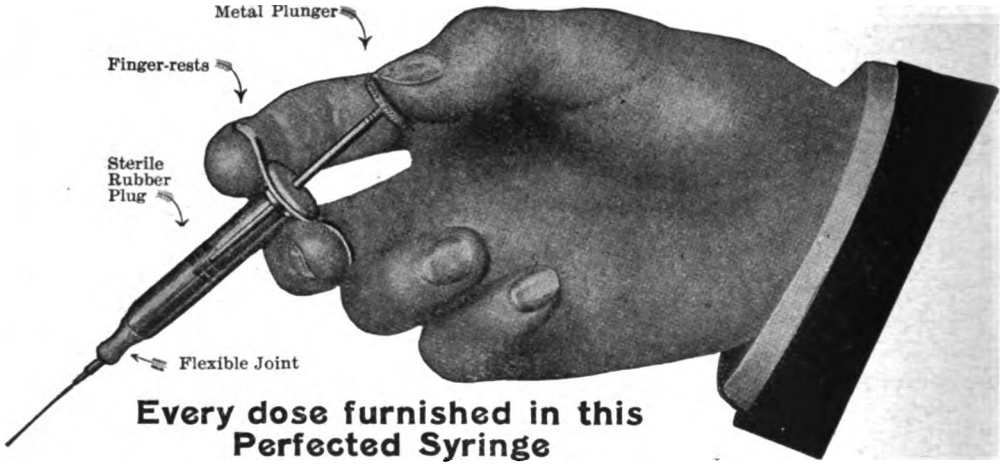

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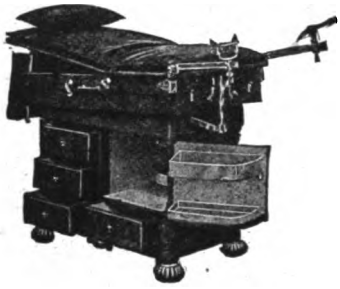

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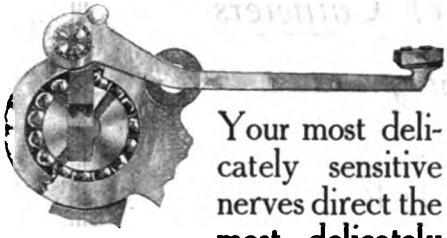

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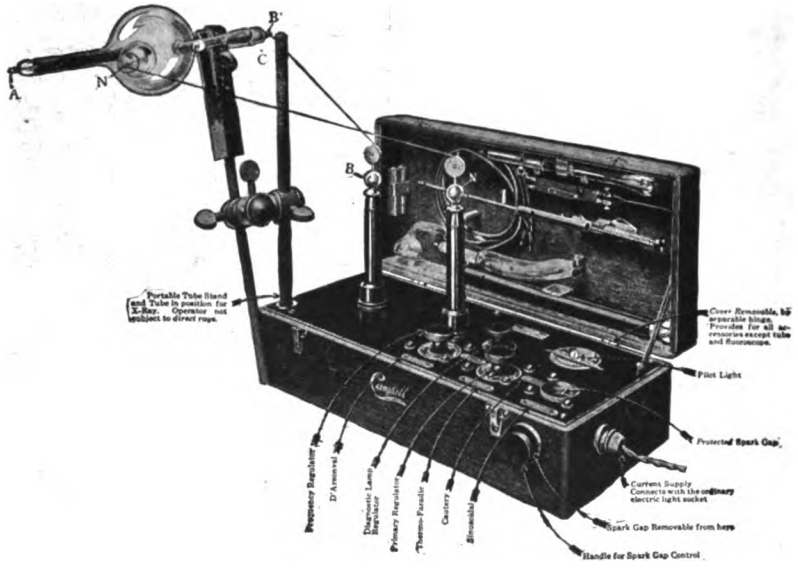

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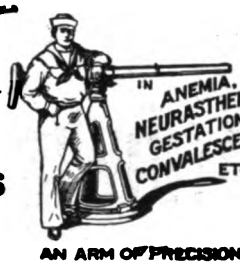

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Vol. XIV. INDIANAPOLIS, IND., September 15, 1911. No. 9

ORIGINAL COMMUNICATIONS.

PRACTICAL VALUE OF AUTOGENOUS VACCINES IN MODERN MEDICINE. DESCRIPTION OF METHOD. ILLUSTRATIVE CASES.

By Fred Hershman, M. D., Indianapolis.

This thesis, completed under the direction of Dr. S. E. Earp, with an interneship for the year 1910-11, in the Indianapolis City Hospital, was submitted for the degree M. D., cum laude, which was granted by Indiana University.

For centuries past it has been known that following an attack of certain acute infectious diseases there remains a certain loss of susceptibility to the contraction of a second attack of the same disease. Early in the 18th century this experience was utilized by vaccination for smallpox. About the middle of the 19th century attempts were made to induce immunity by inoculation of killed or attenuated cultures. Pasteur experimented with chicken cholera and had some success in his efforts at producing immunity. Recently Haffkine has successfully immunized against cholera and Pfeiffer and Wright against typhoid. It came to be seen that establishing an immunity in a healthy individual although a good thing, was not practical. To immunize each individual against all the diseases and infections to which he is exposed would be an impossibility. Hence in order to make it more practical and efficient it became evident that some means must be devised whereby immunity might be established after contraction of the disease. The first great step in this direction was made by Wright, and in 1906 he was able to say that he had by this method achieved uniform success. Wright depended upon the opsonic index as his indicator for dosage and time of

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administration. This was a serious objection to his method for it placed it beyond reach of the general practitioner. The opsonic index has been recently discarded for the reason that it was found that the size and frequency of the dose could be better determined by the clinical symptoms.

Having been given such a practical means of combating disease, it now becomes necessary to make a careful selection of cases satisfactory to its use. Almost any disease or infection in which the etiologic pathogenic bacteria can be obtained and grown on culture, may be treated with autogenous vaccines. Their use is contraindicated in acute conditions and in conditions where the patient is extremely toxic. The best results are obtained in subacute and chronic localized infections by the ordinary pus-producing bacteria. Tubercular conditions yield less readily but oftentimes the destruction produced by secondary infection can be minimized by the use of the vaccines.

Case 1. John Stereum, age 51. Came to the hospital July 2, 1910. Diagnosis, empyema, rt. side. Six days later a rib was resected, the right pleural cavity opened and 2½ quarts of pus removed. A rubber drainage tube was inserted for further drainage of the pleural cavity. This tube was left in place for about one month. It was then removed and the pus allowed to drain through the artificial opening in the chest wall. With the exception of losing considerable weight the patient remained about the same till Nov. 1, 1910 when a peculiar condition developed. When he would lie on his left side he would be seized with violent attacks of coughing and would expectorate a purulent material exactly like that which drained from his side. On Nov. 7th, 128 days after coming to the hospital a vaccine was made and 2 minims given. Three days later a diminution in the amount of pus was noted. Nov. 14th four minims of vaccine were given. Four days later the discharge had stopped. The patient continued to improve and on Nov. 29th 8 minims of vaccine were given. Two days later he left the hospital feeling fine. I saw him a week later. The opening in his chest had closed and he was taking on weight rapidly. The last time I saw him was Feb. 2, 1911. At this time he said he was feeling well and had gained four pounds in two weeks.

Case 2. Mr. S. Grady. Age 40. Patient came to the hospital January 17, 1911 with a deep incised wound of the left side of the neck and another on the left side of the chest. The wounds were sutured in the usual manner and the patient put to bed. Five days later the wound in the side of the chest began discharging pus. At this time some of the stitches were removed in order that freer drainage might be established. Five days following this a counter opening was made for purpose of drainage. For four weeks following this, the wound continued to discharge pus in spite of efforts at drainage, irrigations of normal salt and bichloride solutions and filling the cavity with bismuth paste. On Feb. 27, forty-two days after the patient entered the hospital, one minim of autogenous vaccine was administered. On the following day a mild local reaction at the site of injection was noted. On the second day after the injection the amount of pus coming from the wound had greatly diminished. On the fourth day there was only a small amount of pus and the wound was healing rapidly. On the fifth day three minims of the vaccine were injected. On Feb. 7th the patient was discharged from the hospital sound and well. Total number of days in hospital after first injection of vaccine, eight.

Case 3. Thomas Layden, age 2 years. Came to the hospital June 2, 1911. Left knee and thigh much swollen and very painful. Temperature 104, pulse 134, respiration 28. Diagnosis, osteomyelitis.

On the following day the patient was given a general anesthetic, an incision made on the inner side of the thigh and a large amount of pus evacuated. A rubber tube was put in for drainage and the knee put up in a plaster cast. The wound was irrigated and dressed each day but

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the patient continued to run a septic temperature and did not improve. Finally on Jan. 20th a more extensive operation was performed. The upper end of the tibia and the lower end of the femur were opened and curetted. The drainage now seemed to be free but the patient still remained septic, temperature ranging from 101 to 106.

On Feb. 3rd, thirty-two days after coming to the hospital, it was decided that the leg must be amputated in order to save the boy's life. Consequently he was prepared for operation and sent to the surgery. On account of the patient's weakened condition the surgeon changed his decision and did not amputate, but advised the use of an autogenous vaccine.

On Feb. 8th one minim of vaccine was given. A slight local reaction followed but no change could be noted in the wound. On Feb. 14th two minims were given. A good local reaction followed and in a few days the leg seemed improved. Feb. 20th four minims of vaccine were given. Feb. 27th, six minims were given. Patient improving. March 5th, patient's temperature returned to normal and remained so. March 6th, eight minims of vaccine were given. On March 17th a new vaccine was prepared and 6 minims given. March 26, 6 minims of the same vaccine were given, patient improving. He now plays with the other children in the ward. Temperature normal, leg has only a slight discharge. April 19th had gained twelve pounds since beginning the vaccine treatment. May 3rd a third vaccine was prepared and four minims given. May 8th the patient was discharged from the hospital feeling fine, temperature normal and leg entirely healed. Total number of days in hospital, 125.

Case 4. Jane Gwynn. Age 43. Gave birth to a child Oct. 14, 1910. Three weeks later the right mammary gland became infected. A few days later the abscess ruptured through the skin just above the nipple. The breast was treated by the family physician till Feb. 14, 1911 when she came to the hospital. Upon arriving at the hospital the breast was found to be swollen, tender, indurated and pus escaping from a small opening above the nipple. The opening in the breast was enlarged and freer drainage established. The breast was now sponged with fifty per cent alcohol and dressed in plain sterile dressings each day for two weeks. At the end of this time no improvement could be noted. Tube drainage was now inserted and daily irrigations of the breast were instituted. This was continued for three weeks with little improvement. A counter opening was now made below the nipple and a drainage tube inserted. A large amount of pus continued to drain from the breast each day but no improvement could be noted. Finally it was decided that an autogenous vaccine should be made and if after giving this, no improvement resulted, the breast must necessarily be amputated.

April 27th, seventy-three days after coming to the hospital, one minim of autogenous vaccine was given. A slight local reaction followed. At the end of a week, the condition of the breast was unchanged. Three minims of vaccine were now given and a good local reaction followed. Three days later the discharge of pus had ceased and the patient was much improved. Four days later six minims of vaccine were given. May 18th twenty-one days after the first injection of vaccine, the patient was discharged from the hospital with the breast entirely healed. Total number of days in hospital, ninety-four. Total number of days in hospital after first dose of vaccine, twenty-one. Total number of doses of vaccine given, three.

The technique of preparation of the vaccines used on the above cases was as follows: First a culture is taken from the site of infection. The culture media used is either nutrient agar or Loffler's blood serum. This culture is incubated at body temperature till a good growth appears. The time required for this is from twenty-four to seventy-two hours. Then two to four c. c. of sterile normal salt solution is poured into the culture

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tube and the tube gently shaken till all the growth is dislodged from the culture media and suspended in the salt solution. This suspension is then placed in a sterile test-tube and the tube sealed in a flame. The sealed tube is then shaken thoroughly for ten or fifteen minutes or until all the clumps of bacteria are broken up and a perfect emulsion produced. The next step in the technique is the standardization or the means of determining how many bacteria each minim of the emulsion contains. This step is very important and should always be carefully done. A small amount of the bacterial emulsion is drawn into a capillary pipet. This is forced out upon the end of a clean glass slide. An exactly equal amount of blood taken from an individual whose red count is known, is taken and thoroughly mixed with the bacterial emulsion on the slide. This mixture of blood and bacterial emulsion is now smeared evenly on the slide, allowed to dry in the air and then stained with Wright's stain. After staining the slide is placed under the microscope and a comparative count made. In order that the size of the field may be lessened and the counting made easier; a round piece of paper with a small hole in the center is placed inside the eyepiece. After getting a good focus with the oil immersion, the counting is begun. The number of red cells in the whole field is counted and placed in one column and the number of bacteria is counted and placed in another column. After the first field is counted, the slide is moved and another counted. By a simple problem in proportion, the number of bacteria in each c. c. of the emulsion can be determined and the proper dilution made. The emulsion is diluted so that each minim contains one hundred million bacteria. The standardized emulsion is now put in tubes, sealed and sterilized at 60° centigrade for one hour. It is then ready for administration.

For administering the vaccine I use an all-glass hypodermic syringe, graduated in minims. The site of injection is the subcutaneous tissue of the arm in the adult and of the interscapular spaces in children. Ordinary care is used in sterilization of the syringe, needle and site of injection.

The initial dose for mixed infections is one minim, for pure streptococcic, one-half minim and for pure staphylococcic, two minims. The amount and time of administering subsequent doses is determined by the clinical symptoms. If only a mild local reaction results from the injection, the dose may be doubled. If there is a marked general reaction (high fever, etc.) the dose should be one-half that of the preceding. All local and general symptoms must subside before repeating the injection. The frequency of administration varies from five to ten days or longer: The average is seven days. If the patient does not improve after two or three doses, or if he improves for a while, then remains the same or gets worse, make a new vaccine. The predominating bacteria in an infection often changes, especially during vaccine treatment. This may be because all the varieties of bacteria are not obtained in the culture or new varieties may have been introduced from without.

In conclusion I wish to say that autogenous vaccines are not a "cure all." Yet among the modern methods of combating disease they occupy a high position. They are practical, scientific and within reach of the general practitioner. In order to get the best results, utmost care is essential in preparation and administration. Where other methods of treatment are indicated they should be used along with the vaccines.

NOT THE FIRST.

A reporter was interviewing Thomas A. Edison. "And you, sir," he said to the inventor, "made the first talking machine?" "No," Mr. Edison replied. "The first one was made—long before my time—out of a rib."

—The Doctor.

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DIFFERENTIAL DIAGNOSIS OF EXTRAUTERINE PREGNANCY.*

By B. Van Sweringen, M. D., Fort Wayne, Ind.
Gynecologist to Lutheran Hospital.

It is not intended in the short time allowed for the reading of papers before this society, to present a complete discussion of this subject in all its phases but rather to go over the symptoms and signs present about the time of rupture and then to ask ourselves what conditions there are which might simulate such a picture and lead to confusion if not to unnecessary operation or to disastrous delay.

The subjective symptoms of ectopic pregnancy are those of normal pregnancy, that is, morning sickness or nausea, enlargement and tingling of the breasts, etc.

These symptoms while not so marked as in intrauterine pregnancy are nevertheless present to some degree in the majority of cases. Harris, in a paper read before the last meeting of the A. M. A. and published in a very recent issue of its Journal, makes the statement that "morning sickness and enlargement of the breasts, which are the ordinary symptoms of intrauterine pregnancy do not belong to the symptomatology of extrauterine pregnancy."

In several text-books which I have examined this statement is distinctly refuted, and my own experience, while not great, bears out the assertion that morning sickness and enlargement of the breasts are often met with in extrauterine pregnancy.

Williams, of Johns Hopkins, says: "Unfortunately, the manifestations belonging to an uninterrupted extrauterine pregnancy are not characteristic, and the patient and her physician are usually entirely unaware of the existence of any abnormality until rupture or tubal abortion occurs. Ordinarily the patient considers herself pregnant, presents the usual subjective symptoms and possibly suffers from slight pains in one or the other ovarian region, which she regards as the usual concomitants of her condition. In rare instances, indeed, she may have no idea that she is pregnant, and rupture may occur and perhaps prove fatal, even before she has missed a single menstrual period."

There may be cessation of the menses, or at least menstrual irregularity and the discharge of decidua, or a scanty dark-colored flow, or on the other hand a prolonged profuse bloody discharge, which may lead to the diagnosis of early abortion and curettement.

Vaginal examination soon discloses a mass outside the uterus in the tubes or culdesac.

A large proportion of tubal pregnancies rupture during the second month. This produces pain and hemorrhage.

The pain of rupture is sudden in onset, severe, colicky in character and located in the pelvis or lower abdomen usually though I have seen notable exceptions to this. It is often accompanied by syncope or at least a feeling of faintness, and by nausea and vomiting. Then the face becomes rapidly pale, the lips blanche, the respirations grow sighing in character, the pulse rises rapidly in rate and becomes thready, and we have the sypmtoms of hemorrhage typically present. This picture indicates immediate operation.

There are some conditions which resemble this very closely at some time in the course of their development and while it may seem as though the complete description is widely different yet at certain periods there may arise a serious question as to what is responsible for the symptoms in a given case.

There is intestinal obstruction (notably volvulus) of which Osler says, "Constipation, pain in the abdomen and vomiting are the three important symptoms.

*Read before the Ft. Wayne Medical Society.

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Pain sets in early and may come on abruptly while the patient is walking, or more commonly, during the performance of some action. It is at first colicky in character, but subsequently it becomes continuous and very intense. Vomiting follows quickly and is a constant and most distressing symptom.

At first the contents of the stomach are voided and then greenish bile-stained material and soon a brownish-black li quid with a distinctly fecal odor. The constitutional symptoms from the outset are severe. The face is pallid and anxious, and finally collapse symptoms supervene. The eyes become sunken, the features pinched and the skin is covered with a cold clammy sweat. The pulse becomes feeble and rapid. There may be no fever."

Now in the early part of this history there is a time when it must be thought to bear some resemblance to that of rupture of a tubal gestation sac. In obstruction we ought to find no history of menstrual irregularity and there may be such a history in ectopic pregnancy.

Another condition which may be mistaken for it is the attack of nephritic colic in the female. The sudden onset of agonizing pain in the lower abdomen on one or the other sides may be due to the passage of renal calculus. When the attack is typical this pain begins in the back or loin and runs down to the meatus. Frequent desire to urinate may be present in both the tubal pregnancy at the time of rupture and the kidney colic, although more usual and pronounced in the latter. Then again blood is apt to be found in the urine in the case of calculus or pus if the case be one of pyelitis. It is not always recognized that severe pain resembling that due to calculus is seen in pyelitis without stone. The constitutional symptoms may be the same in both cases, that is, rapid weak pulse, sweating pale skin and collapse. There should be nothing unusual in the monthly periods in the case of stone although a woman two months pregnant might pass a stone. In one of my cases a woman six months pregnant had a typical attack of nephritic colic.

In people suffering from ptosis of the kidney painful paroxysms occur which bear some resmblance to the subject under discussion. The pain may come on suddenly (usually while riding) and be accompanied by nausea or even vomiting. It is usually located on one side or the other but may be felt in the hypogastrium. These symptoms are produced by twisting of the ureter and the amount of urine is therefore reduced while the twist is present and very much augmented when the kidney slips back into place. Then too, while these sudden paroxysmal attacks do occur alone there is usually a history of a dull aching dragging pain in the side frequently present, and again, Dietl's crises do not give the symptoms of internal hemorrhage.

Torsion of the pedicle of a small or medium sized ovarian cyst or dermoid may produce symptoms closely resembling rupture of an ectopic gestation sac. Careful examination here will reveal a rather large mass which will not fit in with the menstrual history, that is, it will probably be too large for a two months gestation which is the most usual time of rupture.

The torsion almost always occurs while engaged in exercise which may or may not be the case in rupture. The pain is much alike in both; it may be accompanied by syncope and nausea and vomiting. The pulse grows rapid and weak in both, although the hemorrhage of rupture if free in the peritoneal cavity and not into the broad ligament should produce more rapid and pronounced effect upon the pulse. There should be no history of deranged, early or delayed menstruation in the case of torsion and there is very likely to be in rupture although this depends on the time rupture occurs and even when this accident is delayed till the second month, there may have been nothing unusual about the menstruation.

The difference in the character and location of the pain should serve to distinguish between ordinary abortion and rupture or at least make one suspicious,

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and the pelvic examination should clear the matter up.

To illustrate the difficulties of diagnosis let me recite the following case: Mrs. K., 30 years old and healthy. Had two miscarriages at three and six months respectively. Menstruation regular until the last period which was three weeks late, scanty in amount and dark in color. She had some morning sickness and supposed she was pregnant. She began to flow three weeks after she was due and while at stool experienced a sudden severe pain in the lower abdomen which caused her to faint. She was discovered in this condition and carried to the farm house when help was summoned. The doctor on his arrival gave her half a grain of morphia before the pain was controlled and then removed her to the hospital for operation on account of the fact that her pulse continued to increase in frequency and decrease in volume. Vaginal examination disclosed a mass behind the uterus about the size of a small egg. Some blood was found in the vagina, but no shreds. Abdominal palpation revealed an exquisitely sensitive area in the left inguinal region which could not be satisfactorily palpated even though she had had a half grain of morphine. Diagnosis of ruptured tubal pregnancy was agreed to by three of us and immediate operation recommended. When the belly was opened a large cystic ovary on the left side was found which was allowed to remain after all the small cysts were punctured and treated, and a very sharply retroflexed uterus which accounted for the mass in Douglas' pouch was straightened out.

There was also found an innocent looking band, probably the remains of the left vitelline duct extending from the belly wall to near the mesenteric attachment on the left side. There was no bowel under it or over it; nor could we find any place on the bowel which looked as if it might have been recently strangulated. The band was divided. Nothing else was found in any other part of the abdomen which could by any possible stretch of the imagination be held accountable for the symptoms. The subsequent course of the case was uneventful. The pain and tenderness disappeared at once and she went home in two weeks perfectly well. The urine was scanty for the first twenty-four hours but although a generous precipitate formed it contained no pus and was made up of urates. I do not know how to explain this case, unless the band above mentioned caused a sudden strangulation which was corrected before the belly was opened.

In the discussion of Harris' paper before mentioned, Dr. J. H. Carstens said that he did not agree with Dr. Harris that the diagnosis of the condition was an easy one to make. In the first place the women never know they have extrauterine pregnancy. They feel all right, and it is only when symptoms appear that the woman is made aware of her condition. One can very often be mistaken in these cases, for a woman will have some old chronic trouble and will have an ache on the side on which she has had trouble. The doctor is called in and treats her for another one of her usual attacks. Dr. Carstens did not blame the family physician in the absence of flow and rapid pulse indicative of hemorrhage, for making a mistake. On one occasion he was called to see a woman on whom he had operated for left tubal disease. The doctor in attendance said it was a case of appendicitis and Dr. Carstens agreed with him. There was pain over McBurney's point; temp. 100.5°, pulse 84. On opening the abdomen much blood and a ruptured tubal pregnancy were found. Another instance was that of a woman thrown out of a street car. Dr. Carstens found a boggy mass in the posterior culdesac, and the pulse was increased from 100 to 150. He thought the woman had an extrauterine pregnancy which had ruptured when she was thrown out of the car. She had flooded a little before. He opened the abdomen and found neither blood nor extrauterine pregnancy, but a pregnant uterus tilted over into the culdesac. He straightened out the uterus and clos-

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ed the abdomen. The pulse went down and the woman recovered."

In the discussion of the case here reported by those interested it was agreed that the old rule that any woman of child-bearing age who is suddenly seized with a severe pain in the lower abdomen which is followed by fainting and vomiting and increase in the rapidity of the pulse is the subject of ruptured ectopic pregnancy has some exceptions in the light of the present case for we could not imagine any history more typical of ectopic pregnancy than ours.

The following case came under my own observation and while the existence of an ectopic gestation was suspected from the first there were a few days when it was thought to be a slow uterine abortion. Mrs. T. F., 33 years of age, married seven years without conceiving, came to me on Sept. 23 complaining of a continuous flow from the vagina which had lasted for four weeks.

She had not missed a period and the last menstruation came on time. She had had some morning nausea but no vomiting. Tingling sensations in the breast were also present. Vaginal examination showed no unusual tenderness and no mass could be felt in either side. The cervix was soft and the womb slightly enlarged. Probable pregnancy was diagnosed and the dangers of tubal gestation explained to her so that we might not be prevented from operating on her should our suspicions prove correct.

On October 4th I was sent for and found that on the 29th of the preceding month she had had a sudden severe pain in the abdomen which was followed by a feeling of extreme weakness and fainting. Her pulse then was 130. Immediate laparotomy was proposed and refused. She gradually recovered her strength and color and the tenderness in the right groin subsided.

On October 13th she had a similar but more severe attack and was removed to the hospital where laparotomy was speedily performed on account of the fact that she had no pulse at the wrist during the procedure, and the specimen here presented obtained. She is making a good recovery at this time from her very severe hemorrhage. We estimated that there were at least three pints of blood removed from the peritoneal cavity.

THE INDUCTION OF GENERAL ANESTHESIA BY THE ADMINISTRATION OF ETHER.

By Edwin E. Dougherty, M. D., Indianapolis.

This thesis, completed under the direction of Dr. Goethe Link, with an internship for the year 1910-11, at the Indianapolis City Hospital, was submitted for the degree M. D., cum laude, which was granted by Indiana University.

HISTORY.

Sulphuric ether was discovered by Valerius Cordus in the year 1540 and was called by him "Oleum Vitriole Dulce." By some its discovery is attributed to the Arabian chemist Djafar Yeber.

In 1846 William Thomas Green Morton, a medical student, at the suggestion of his preceptor, Dr. Charles Jackson, of Boston, Massachusetts, experimented with sulphuric ether on animals. Being successful, he then tried personal experiments by inhaling ether from a handkerchief, while sitting in his operating chair; he became unconscious for several minutes, and on regaining consciousness was so elated by his success that he decided to submit to the extraction of a tooth while under the effect of ether. When he was ready to make the experiment, the office bell rang and a patient

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was admitted, upon whom Dr. Morton successfully used the ether for an anesthetic. To Dr. Morton, therefore, was given the honor of having discovered the anesthetic property of ether, on November 3, 1846.

CHEMISTRY.

Ether, also called ethyl-oxide, ethylic ether, vinous ether and sulphuric ether, has a chemical formula of $C_4H_{10}O$. It is a diffusive, transparent, highly volatile, thin liquid, very inflammable, with a refreshing odor, a sweet, burning taste, a bitter after-taste and a neutral reaction. It is soluble in alcohol, chloroform, benzol, benzine, fixed and volatile oils, and in eight times its volume of water at 60° F. The boiling point is about 98.6° F.

A stronger ether (ether fortior), not suitable for anesthesia, is composed of 94 per cent ethyl oxide and about 6 per cent of alcohol containing a little water. The specific gravity of ether for anesthesia should not be higher than 0.725 at 60° F. Ether is usually obtained by the action of sulphuric acid on alcohol.

The grade of ether recognized by the United States Pharmacopeia as suitable for use for anesthesia has a specific gravity of from 0.725 to 0.728. In order to determine the purity of ether the following tests are used: (1) Light blue litmus paper moistened with water should not be changed when immersed in ether for 10 minutes. (2) If ether be agitated with carbon disulphide, it becomes milky and turbid, if water is present. (Boettger.) (3) Upon evaporation, ether should leave no residue. (4) If allowed to evaporate spontaneously, there should be no perceptible foreign odor present when the last traces of ether have disappeared. (5) There should be no change of color on the addition of KOH. This detects the presnce of an aldehyde.

PHYSIOLOGY.

Locally, ether is a violent irritant. In excss, it probably depresses all higher senses, but it especially acts upon the cerbum and the sensory and motor sides of the spinal cord. It usually produces death by asphyxia, due to depression of the respiratory centers. Its first action upon the circulation is that of a stimulant to the heart and to th vaso-motor center. It also stimulates the respiratory center.

THERAPEUTICS.

Ether is given internally as a stimulant and carminative, in doses of one-half drachms. Hoffman's anodyne (ether, alcohol, and a heavy oil) is frequently given internally to relieve abdominal distention. Ether is most often administered to produce anesthesia for surgical purposes. It is this therapeutic use which we wish to consider.

Clinically, we may divide the effects produced by the inhalation of ether into four stages, as follows: 1st, Disordered consciousness and analgesia; 2nd, Unconscious reflex activity; 3rd, Surgical anesthesia or coma; 4th, Bulbar paralysis.

In the first stage, inhalations of ether cause free secretion of mucus in the fauces, because of its irritant character. A choking and suffocating sensation will occur if the vapor is too concentrated. A sense of fullness and pressure in the head, noises in the ears, a feeling of warmth, tingling or a pleasant numbness of the body may soon be felt. The pulse becomes quickened, the respiration is accelerated and somewhat jerky, and deeper than normal. The pupils are dilated and quite mobile.

In the second stage, consciousness is slowly or abruptly lost, the memory is lost, the actions are not rational. Laughing, singing or struggling may occur, especially in robust subjects, who require considerable ether. The face is flushed; perspiration breaks out on the face, forehead and body; the conjunctivae become injected; slight cyanosis may appear; mucus and saliva are freely secreted; the pulse is bounding and more rapid than normal; the breathing is irregular from muscular spasms. There may be temporary suspension of respiration in muscular subjects.

In the third stage, respiration becomes forcible and regular and there is usually more or less rattling from the presence

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of mucus in the pharynx and larynx; the cornea is not sensitive to touch; the extremities are relaxed; the pulse is slower than in earlier stages, but full, bounding, and regular.

In the fourth stage, the heart's action is feeble, irregular and almost imperceptible. Paralysis of the cardiac ganglia and of the automatic power of the myocardium soon follows.

TECHNIC OF ADMINISTRATION BY INHALATION.

The administration of ether for surgical anesthesia should not be intrusted to a novice. It is important, first of all, to examine the heart, lungs and urine. Place the patient upon the operating table, and remove any foreign object, from the mouth; rub sterile petrolatum on the face to prevent blistering where it is to be covered by the ether. Have the patient breathe through the nose to prevent the secretion of mucus in the mouth, and place a folded towel over the eyes and mouth, leaving the nostrils exposed. A wick of gauze may be put in one corner of the mouth to draw off the mucus.

Beginning with one drachm of ether, let the patient get gradually accustomed to it. Dilute it well with air by holding the inhaler an inch from the face slowly drawing nearer. In this way the feeling of suffocation is avoided. As the patient approaches unconsciousness, hold the mask closely so as to shut out the air, and the third stage of anesthesia will be quickly reached with very little excitement.

The signs indicating favorable progress during the operation are a full and regular pulse, deep respiration, a slight snoring, a flushed face and slightly dilated pupils. Cyanosis is the sign for more oxygen, prolonged forcible expiration indicates that less ether should be given. The anesthetist must carefully observe the state of respiration, which is the most reliable guide, also the condition of the pupils, pulse, color, swallowing movements and degree of muscular relaxation.

The manner of administration may differ according to the method and the inhaler used. Ether is administered by inhalation by methods known as the open, semi-open and closed. It may also be given per rectum.

When the open system is used, plenty of air is mixed with the ether, which is dropped on a mask held closely to the mouth or nose. This system is most often used with young children, weak or exhausted persons, or those who have been under the influence of ether often.

The semi-open method is preferable in a great many operations; the air used is limited; the expired air and vapor escape and there is no re-breathing. A number of inhalers may be used in this method, the best of which are Allis's and Blake's. The Goldan inhaler is adapted for either the open or closed method.

In the closed method the amount of air is restricted and under control, and the expired air is re-breathed. The Clover, Packard and Benett inhalers are among those devised for this method.

Ether and oxygen are sometimes given in combination; this method has not been used extensively. A tube from an oxygen cylinder is connected with any inhaler adapted for the purpose (Packard inhaler) and a variable percentage of oxygen is admitted along with the ether. This combination is adapted to a very weak heart, as in alcoholics and persons of feeble vitality. The ordinary Allis inhaler can be made to serve for this method.

Ether, in our opinion, is best given by a partially open inhaler. Allis's inhaler is the most satisfactory, as it secures a plentiful supply of air. When using the Allis inhaler, care should be taken that none of the drug runs through onto the face. Even the vapor is irritating to the eyes. Boracic acid solution should be used after the administration to flush out the conjunctival sacs.

Probably the safest way to administer ether, and the most comfortable for the patient, is to take a piece of gauze or an Esmarch mask and give the drug drop

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by drop. This is often referred to as the "drop method."

RECTAL ETHERIZATION.

Pirogoff suggested this method in 1847 and Roux used it in the same year. Its use has been extensively revived in recent years.

This method is used only in operations about the face, tongue, nasopharynx, larynx and mouth. The rectum should be emptied by an enema previous to the use of the anesthesia. A dose of laudanum is given a few hours before the operation. Buxton's type of apparatus is used, which prevents liquid ether from passing into the rectum. This method should never be used if the intestines are irritated or inflamed. It has never come into general use. It irritates the large intestine, often produces colic, also often leads to protracted stupor.

Buxton's type of apparatus is as follows: A tube containing ether is set in a vessel containing water at a temperature of 122° F. The ether tube is joined by a glass tube and rubber pipe to a glass globe, the globe being connected by a rubber pipe to the tip, which is inserted into the rectum. If ether vapor condenses into liquid in the glass globe, the globe should be emptied at once.

AFTER-EFFECTS OF ETHER ANESTHESIA BY INHALATION.

There is scarcely any danger connected with the administration of ether to a healthy subject. It is claimed by some that only one in 20,000 persons who inhale ether die. Others place the mortality as high as one in 5,000.

Experiments of Lindermann, of Moscow, on animals show that when death occurs from too prolonged or concentrated etherization, there is always congestion and edema of the lungs.

If the patient has been anesthetized without being saturated with a large quantity of ether, recovery is usually rapid, but a too free use of ether may be followed by stupor, slight cyanosis, and weak pulse; vomiting often occurs.

Ether leaves a disagreeable taste in the mouth and its odor is present in the breath for some time.

Hysterical, neurotic or alcoholic subjects may exhibit mental excitement, mania or dementia. Chorea has been noted. Cerebral hemorrhage has been reported, also jaundice. Pneumonia is more frequent than was formerly thought. Backache is common and may be largely prevented by placing a small pillow so that it will support the lumbar curve during anesthesia.

Acid intoxication or delayed poisoning is not caused by the actual operation, but may follow the giving of any general anesthetic.

Paralysis may arise during anesthesia as a result of cerebral hemorrhage or embolism.

It sometimes happens that when a person comes out of anesthesia a palsy of some part is found to exist. This may have been caused by pressure of an extremity upon a table edge or from pressure upon nerves by placing the patient in certain positions.

Thomas and Kemp experimenting on animals concluded that ether is dangerous in the presence of renal diseases and bronchitis. It has been claimed that bronchitis is often a necessary sequel of the open method of ether anesthesia. This, we think, is wrong. Such results are due, in our opinion, to faulty use of the method. If the ether is poured into any inhaler in such quantities as to reduce its own temperature by evaporation and consequently that of the inspired air, some harmful results may follow. If the anesthetist drops the ether into the inhaler slowly, no difficulty will be experienced except in cases of iodiosyncrasy in which the mucous membrane is very susceptible to the slightest irritant properties of the ether. Bronchitis and bronchorrhea are due rather to the chilling of the patient's body than to the inhalation of the ether, if it be properly administered. This chilling may take place either during the operation from necessary or unnecessary exposure, or after the operation while moving the patient

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from an overheated operating room through cold corridors.

In an overdose of ether the cornea becomes insensitive, pupils dilated and eyelids separated. The skin may be ashy pale, pulse weak and slower, respiration shows signs of failure, in some cases loses its stertor, becomes more feeble and finally ceases. Respiration usually ceases before the pulse.

ACCIDENTS.

There is a certain class of subjects likely to show accidental conditions during the administration of the anesthetic and the anesthetist must be watchful and prepared to meet any unusual complication that may arise. Patience, firmness and encouragement on his part will accomplish much. There should be at hand atropine, strychnine, ammonia, and nitroglycerine for use in case of cardiac failure.

Coughing often occurs from too concentrated vapor, especially in subjects with irritable throats, and on this account it is sometimes necessary to abandon ether and use chloroform. Hiccough is rare and most likely to occur during abdominal operations. Sneezing may be relieved by spraying the nasal region with a dilute solution of cocaine if not relieved by pushing the ether.

VOMITING.

If the patient has been properly dieted and has been given an enema beforehand, there will be less tendency to vomiting. It may be due to forcing too strong vapor upon the patient, also to the patient's partially emerging from the state of insensibility.

Vomiting often occurs under light anesthesia, during the induction period or during recovery from full anesthesia. It is likely to occur in alcoholic young men or weak women with irritable stomachs or sluggish livers. The quicker the subject is brought under the anesthetic the less liability there will be to vomiting. It, however, often occurs in spite of all that can be done, greatly exhausting the patient and doing infinite harm, especially if the operation is on the brain or an intra-abdominal structure.

After a prolonged operation, if the patient's condition permits, or the nature of the operation does not forbid it, it is well to use a stomach tube and wash out the stomach with warm water.

The remedies for post-operative vomiting are as follows: Have plenty of fresh air in the room, forbid food, give very hot water in doses of teaspoonfuls at frequent intervals; inhale vinegar, give hot, black coffee, use mustard plasters over the stomach, place a small piece of ice in the mouth, or give small doses of iced champagne.

Many persons suffer from nausea but do not vomit; in such cases use one minim of tincture of nux vomica in a teaspoonful of hot water every 10 minutes until 6 doses are taken, or give drop doses of wine of ipecac, or minim doses of dilute hydrocyanic acid.

Obstructed breathing may be caused by hypertrophied tonsils or adenoids in the air passages, or by spasms of the muscles of the upper part of the respiratory tract. In such a case push the lower jaw forward, pull the chin forward from the sternum and upward, extending the head over the end of the operating table. It is often necessary to open the mouth with a gag and to pull the tongue forward from the pharynx. If breathing is not then resumed, strong traction should be made on the tongue and the chest should be compressed. Paralysis of the heart is produced by irritation of the vagi and is relieved by injecting atropine in order to paralyze the inhibitory mechanism. If there is complete arrest of the circulation, it may be thrown directly into the heart by means of a long hypodermic needle.

The effect on respiration is through mechanical stimulation of the superior laryngeal nerve and is not relieved by atropine. Where the trouble is due to mucus, it will generally be relieved by coughing and swallowing, if the administration is temporarily suspended.

As the immediate cause of death is from over distention of the right heart, venesection may be of service. The use

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of oxygen is frequently resorted to. Hypodermics of strychnine, caffein, atropine and camphorated oil may be of value.

If artificial respiration is needed, Sylvester's is the best method. The patient is placed recumbent with the foot of the bed raised. The surgeon grasps the arms just above the elbows, draws them outward and upward until they are nearly perpendicular; they are held for two seconds, while air is entering the lungs. Then the arms are lowered and pressed against the sides of the chest for two seconds, during which time the chest is emptied, as in expiration. These movements of elevation and depression are made 12 or 15 times a minute.

The following are some of the indications for the use of ether instead of chloroform in general anesthesia; chronic pleurisy, fibroid-phthisis, emphysema. It may be used in short operations and may be given in the presence of exhaustion, shock or collapse with open inhaler (McCardie); also in satus lymphaticus, nervous diseases, abdominal and chest operations. It is also indicated in operations upon the rectum, genito-urinary tract, in aortic stenosis, and operations upon the extremities, as in the reduction of fractures, dislocations, treating anchylosis, and painful joints.

Ether is contraindicated in chronic vascular diseases. In nearly all cases of sudden death by ether, grave kidney or heart lesions have been found at the autopsy.

Ether should not be used by inhalation in bronchitis or acute nephritis because it may rupture a blood vessel by raising arterial pressure; nor in diabetes, nor in anemia when the hemoglobin percentage is below 50.

PATHOLOGICAL RESULTS OF ETHER.

The research of Richard Holscher led him to the conclusion that ether pneumonia is due to the inhalation of bacteria from the mouth into the lungs; that during etherization there is practically no irritation of the bronchial mucous membrane by ether; that the rales heard during narcosis are due to the inhalation of saliva, which may largely be avoided by lowering the head, turning it to one side, putting in a wick of gauze and by keeping the mouth as free as possible from secretion. Any obstruction to breathing greatly increases the likelihood of the inspiration of saliva and the subsequent danger of pneumonia.

F. S. Watson and W. T. Bailey (Med. & Surgical Rep., Boston Hospital) have found that with the normal kidney, so far as the so-called Phloridzin Test is concerned, ether increases the functional activity, but when the kidney is already diseased, it seems from the beginning to depress the renal function. Eisendrath states that albuminuria was produced in 25 per cent of his cases by ether, and casts were found in 28 per cent after ether anesthesia. Ogden found tube casts in 70 per cent of ether anesthesia patients. Statements of other investigators indicate that while both ether and chloroform seriously affect the kidneys, ether is less dangerous than chloroform. Buston and Levy failed to produce complete suppression of urine with ether, but did get lessening of the secretion and as a result of their research, they think that there is very little evidence to show that ether has an active and direct influence upon the secreting structure of the kidney.

The clinical conclusions arrived at in regard to ether by the last committee on anesthetics of the British Medical Association are to the effect that complications are more frequent in males than in females, but slightly more dangerous in females than in males.

Either alone is comparatively free from danger in healthy patients. Struggling is more frequent during the use of ether than with chloroform, but rarely leads to danger. Vomiting during recovery is more common with ether but usually of short duration. Bronchitis is more common after ether anesthesia than after chloroform.

The following cases of death due to the administration of ether have come under

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our observation. As the mortality from ether alone is given as high as 1 to 5,000 and as low as 1 to 20,000 we think these cases worthy of record.

Case 1. Mrs. A., 40 years old, apparently healthy except for enlarged cervical glands on both sides of the neck. The glands were both superficial and deep but they were not adherent to each other and were but slightly adherent to the surrounding structures.

She made the remark before going to the operating table that some doctor had treated her for goiter and told her never to be operated on because she would die. In hospital work these remarks are so frequent that little attention is paid to them.

Ether was given by the open method. The patient struggled somewhat but not more than is often seen; the pulse and respiration were rythmic and she appeared to be doing nicely.

An incision about two and one-half inches in length was made over a gland along the anterior border of the right sterno-mastoid muscle and all the glands were dissected out of this side of the neck, with the fingers. The incision was closed except at the lower angle, where a gauze drain was inserted. A similar incision was made on the opposite side of the neck and the glands dissected out in the same manner. No instruments were used after the first incision and the glands were dissected out entirely with the finger.

After the last gland had been removed and the wound closure was about to be made, respiration ceased and the pulse became almost imperceptible and soon disappeared. Everything was done to resuscitate the patient but to no avail. The operation was simple, not consuming more than thirty minutes.

As no vessels or nerves were cut, the death of the patient was attributed solely to the ether anesthesia.

Case 2. Mrs. S. entered the hospital April 19th and was prepared for operation for abdominal tumor.

Ether was administered to the point of surgical anesthesia. Previous to the proposed operation the patient was catheterized and 100 ounces of urine were obtained, thus obliterating the tumer, which was merely a distended bladder. Suppression of urine followed, as well as symptoms of nephritis. The patient died one week later. As no post-mortem was held, I cannot give the pathological findings. There was an examination made of the urine before the anesthesia and no albumen was found. After anesthesia traces of albumen were found.

Forty grammes of ether were used in this case.

Case 3. Mrs. B., 40 years of age, was prepared for a hysterectomy. The urine was examined and no albumen was found. After the operation there was complete suppression of urine. The operation was technically successful. A retention catheter was inserted during the operation and not a drop of urine was passed. The abdomen was again opened to see if the ureters were ligatured, but they were found to be intact. Patient lived six days, suffered great pain and became toxic. Urinary stimulants were used without avail. This patient was under the influence of ether only 30 minutes, and only a small amount of ether was used.

Boyd is a bright little fellow of three years. One day his mother observed him vigorously scratching his head and asked:

"What makes you scratch your head?"

"Because I'm the only one that knows it itches," he replied quickly.

—Med. Standard.

THE WAY IT COMES AND GOES.

The funny man on the editorial staff of the weekly Bulletin of the Chicago Department of Health puts it thusly: "Consumption comes with a hack and a cough and goes with a coffin and a hack."

—The Lancet-Clinic.

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INDIANAPOLIS MEDICAL JOURNAL

(Central States Medical Monitor and Indiana Medical Journal)

EDITORIAL

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SCHOOL TEACHERS SHOULD PASS PHYSICAL EXAMINATION.

We fully endorse the examination of school children, but we should not forget to include the teacher. The teacher sick in mind or body should never be permitted to attempt to teach healthy children or any other kind of children. The schoolroom is no place for a sick teacher, and the sooner we recognize this fact the better it will be for the schoolchild.

This is the first month of the school year, and thoughts upon this subject are timely. The Indiana State Board of Health has had something to say on this subject which will be given very careful attention. The form of statement issued is as follows:

"The teaching of children should not be done by sick or diseased teachers. School work surely suffers if the teacher is not strong and healthy. If a teacher be nervous or irritable, he or she will do harm to the dispositions of the children. In Indiana the sick-rate and death-rate is higher among teachers than in general life. This is almost certain because there are so many unsanitary schoolhouses. The life of the teacher at home is the same as in general life. Only at school does any difference appear.

"The pupils in unsanitary schoolhouses are held back and made sick, their health is impaired and even death is caused. Twelve hundred school children died in Indiana during the school terms in 1910. The sickness causing their death was forced upon them. The bad air, insufficient light, over or under heating, seats which are not adjusted to the size of the human bodies they contain, horrible outhouses, bad water, etc., do their deadly work. All of these conditions are imposed in the name of economy, and hence would be laughable if so much health, efficiency and life were not wasted. The same unsanitary conditions 'knock' the teachers harder than they do the pupils, because they are longer exposed to them, and, in addition, bear a nervous strain of responsibility.

"By spring most teachers show the strain.' That is, they have lost health. They usually have lost color and weight; they sleep poorly; they have little appetite, and, perhaps, 'a slight cough' (consumption) has appeared. In general life one death in 8.7 is from consumption, and among teachers it is one in six. The invalidism and death which teachers endure on account of unsanitary schoolhouses should cause them to take action and de-

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mand sanitary schoolhouses. But teachers are like most of us . . . . .not until they discover the awful disease has attacked them do they realize their opportunity has been lost.

"All teachers should pass a physical examination as well as one intended to discover mental and educational fitness. They should have a good heart, good lungs, good eyes, good teeth, a straight spine, good digestion, straight body, good hearing, normal scapulæ, a good speaking voice, good nerves, etc. A teacher with chronic cough, catarrh, anemia, bronchitis, sore or weak eyes, chronic rheumatism, dyspepsia, chronic constipation, neurasthenia, any skin disease, etc. should never be employed to teach children. A sickly teacher is certain to be more or less listless and irritable, and will be unable to keep the school work up to the standard.

"Teachers should teach and exemplify health, as well as teach and exemplify culture. Ill health is usually the result of wrong living, and not to know how to live rightly is a terrible indictment of a teacher." S. E. E.

CHESTERTON'S APPRECIATIONS AND CRITICISMS OF THE WORKS OF DICKENS.

Mr. G. K. Chesterton has written a series of prefaces to the Everyman edition of Dickens, which have been collected and put forth by the E. P. Dalton Company in a book of some three hundred pages. The several prefaces constitute an admirable sequel to the biography. Of this series "The Nation" says: "Whenever Mr. Chesterton's criticism approaches the author of "Pickwick," it rises to the highest appreciation of wit and suggestiveness, of robustness, geniality and punctuation. His life of that great middle class genius made at one stroke a reputation for himself, and a new reputation for Dickens, recalling him from that Limbo to which he had been condemned by a priggish and scientific generation." This book is a stimulant. The Dutton Company is to be commended for its 400 volumnes of the world's best literature as 35 cents a volume. There is no similar series so complete in any country. They go easily in the pocket or the grip. They occupy but a very little space in the library; they are well bound in cloth; they can be bought in any large city; if a volume of a set is lost it can be replaced. In leather and gilt at 70 cents, they are fine gift books. Grote's great history of Greece costs $4.20 for the 12 volumes —many people have paid 25 and even 100 dollars for less convenient and readable editions of this great work. Among them are the "Hesperides of Herrick," "Goethe's Faust," complete with notes, and also its necessary companion volume, "Lewe's Life of Goethe"; the "Autobiography of Benuenuto Cellini," and a hundred others that one would be very apt to buy if they were for a moment in the hand or under the eye. And the prefaces and introductions to these volumes are helpful and pleasant to read, as are those by Chesterton, which comprise the volume noted above. A. W. B.

MAY BE MISTAKEN FOR SYPHILIS.

Vincent's Angina.—In a study of 32 cases J. D. Rolleston (British Journal of Children's Diseases, July, 1910) states that Vincent's angina is an uncommon disease, occurring in 0.9 per cent of all cases of sore throat, and in 4.9 per cent. of cases of non-diphtheritic angina. During a five years' period of observation in a hospital population of all ages, the affection was confined to children between two and sixteen years. No instances of contagion were observed. Its incidence was greatest in the spring, least in the autumn. It was not found to show any predilection for weakly children or for cases of oral sepis. There is nothing characteristic in its prodromal symptoms. There are not two distinct varieties of Vincent's angina. The ulcerative is merely a later stage of the membranous form. Constitutional symptoms are slight or absent, but the local affection is more pronounced than in diphtheria. Association with other diseases is uncommon. The prognosis is favorable. Complications

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are infrequent and usually insignificant. Treatment consists in the local application of tincture of iodin or methylene blue powder. Internal medication is usually unnecessary.

The above note, from the "Journal of Obstetrics," does not mention the use of ten pen cent. solution of sulphate of copper which destroys this remarkable organism in one or two applications. Nor does it mention the occasional resemblance of the ulcerative stage to the patchy and serpiginous syphilide. Such a case was seen by Dr. W. Garshwiler, of Indianapolis. He failed to find the spirochete of syphilis by the carbon light and the oblique illuminative. An examination of the blood by Dr. J. Thrasher, of Indianapolis, showed a negative Wassermann which was definite as his work has run true when crossed by examinations of the same bloods in both Johns Hopkins and the Rockefeller laboratories. But Dr. Thrasher was fortunate enough to have found and stained a smear from the tonsil which readily showed both forms of the organisms concerned in this disease. Therefore the proof was positive that the disease was Vincent's Angina in spite of the appearance of the tonsil which clinically showed excellent similitude of a lesion.

A. W. B.

SIGNIFICANCE OF "FLANK PAIN."

The term flank pain perhaps sounds unscientific, and yet as a symptom it sometimes is a means of foretelling dire consequences. Some of the old writers attached to it but little significance, and yet during the last few years more importance has been attached to it. I remember seeing several cases at the Indianapolis City Hospital within a period of fifteen years in which it was not an easy matter at the onset to make a diagnosis between appendicitis and lobar pneumonia. About a year ago Dr. A. C. Kimberlin reported a case to the Indianapolis Medical Society in which a diagnosis had been made of appendicitis and only in the later period were the symptoms of lobar pneumonia manifested. These cases, of course, are not new, but are sufficiently infreqent that it is well to refresh our minds concerning them.

I think it was last January that Bennecke reported an interesting case in the Mediz. Klinik, which has a bearing on this subject: A boy, ten years old, with high fever and the signs of appendicitis, was operated upon but the appendix found normal. The fever continued, and several days after the operation, a typical pneumonia developed, affecting the left upper lobe, and running the usual course. He was able to find in the records of the Jena medical clinic the histories of 21 cases of pneumonia, which at first presented the typical picture of appendicitis or of general peritonitis. Their subsequent course proved that there was no real peritoneal involvement. Pneumonias of the right upper lobe seem chiefly to dispose to this symptom-complex, which is most commonly found in children.

S. E. E.

USEFULNESS OF OPIATES AND THEIR HARMFULNESS IN CHILDREN.

If the preparations of opium are good remedial agents for the adult the same should be true in the case of child. It is not the preparation itself that is of so much importance but the failure to recognize the indications for its use and the proper dose. Many of us were taught in the lecture room that opium should be avoided in the treatment of children, and, in fact, book statements were made that opium was contraindicated in infancy and old age. Nothing can be more fallacious, and it is time to recognize there are certain diseases of childhood in which no remedial agent is superior to opium. If there are untoward results because it is improperly administered the ignorance of the prescriber is often largely responsible and there was a time when fear prevented the use of this agent, and a sin of omission was the cause of detrimental results. That opium is contraindicated in childhood is one of the things we have had to unlearn.

Lust (Ann. de Med. et Chir. Inf., No-

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vember 1, 1909) says that opiates are not contraindicated in infants, as has been supposed, but on the contrary, are of great value in spasmodic conditions. We should avoid preparations of opium which contain all the alkaloids and other principles of the drug, and should confine ourselves to morphin given hypodermically or by mouth. The tolerance of infants for this drug is equal to, or greater than that of adults if its dosage is based not upon age but upon weight. Morphin is a simple, stable product, the dosage of which can be given with precision. It should be one-half milligram for every kilogram of weight in each twenty-four hours, well diluted, or one-half as much by hypodermic injection. There is no fear of accumulation, and the dose may be increased without fear. S. E. E.

THE TREATMENT OF ULCERS WITH GELATIN-GLYCERIN-ZINC-OXIDE PASTE AND WITH USE OF SCARLET RED OINTMENT.

B. A. Thomas (University of Pensylvania Medical Bulletin, October, 1910) recommends the following paste, in the treatment of leg ulcers and other similar lesions: Two parts of the purest gelatin are dissolved by means of a hot water bath, in five parts of water. While the mixture is still hot, five parts of glycerin and two parts of powdered white oxide of zinc are energetically stirred in, until the whole is cooled. Recently the author has also added carbolic acid, three per cent, to the mixture. At room temperature, the paste assumes the consistence of ordinary table gelatin. The paste is liquified in a hot-water bath, just before it is used, and is then cooled sufficiently so that it will not injure the skin. In the meantime, the patient's leg is thoroughly cleansed with water and soap, alcohol, and a solution of mercury bichloride. The surface of the ulcer is also disinfected with hydrogen peroxide and a solution of bichloride. The ulcer is then dried thoroughly and the paste then applied over the entire surface of the leg from the ankle to the knee. A layer of gauze is then applied, covered by another layer of paint, and so on, until three or four layers of the gauze have been applied, finishing with the paste mixture. Over the outer paste layer a coating of shellac is applied as soon as the dressing has solidified. Instead of the shellac the paste may be covered with a very thin layer of cotton, with talcum powder or with a bandage.

Frequently, this dressing may remain in place for from two to eight weeks, and when removed the ulcer will be found to have healed. It is safer, however, to inspect the dressing in two days, and if the dressing is found saturated by discharge, a window must be cut in the dressing, and the ulcer cleansed, and treated with dry dusting powders.

The above, from the "Medical Review of Reviews," contains a method the writer of this note has printed in the "Journal," and has used and can approve. Such ulcers, if on swollen legs—the common place and condition—may be treated with scarlet ointment with good results according to the detail of Dr. Davis, of Johns Hopkin's Dispensary as set forth in full in the "Johns Hopkins' Bulletin," of June, 1909, and again in the "Annals of Surgery," of January, 1910. Dr. Davis' article in the "Annals" is abstracted very fully in the "Indianapolis Journal," of 1910, which our readers may look up. His writings have been much quoted. His third article appears in the "Annals of Surgery," of May, 1911—some 20 pages with illustrative plates and a bibliography of over 50 titles nearly all from German authors. In the last article he charges us that the 5 to 8 per cent. scarlet red ointment will not eliminate skin grafting in the majority of large ulcers, as some have taught. He also calls attention to the bladder disturbances of workers in dye manufacturers, which use amido combinations of benzol and napthalin. These men have cyanosis, stupor and weakness, casts and bloody urine, and after long handling of these dyes there may be hemorrhages and tumor formation in the bladder. But these extreme results are not observed in the use of the small quantities of scarlet red ointment used in

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treating burns and ulcers. Dr. Davis has treated very large granulating areas for long periods without any deleterious result. His last article is very valuable and should be studied by those using the red ointment as a routine treatment.

He says in closing, that scarlet red (or even its essential component, amidoazotoluol) will not heal every wound, but in the majority of cases, when applied with the proper technic, they will cause stimulation in the edges of the most sluggish wounds, and give a rapid healing which is stable and resistant, and which has the macroscopic and microscopic appearance of the normal skin. There is no tendency to subseqent thinning, and the skin becomes movable and the underlying tissues soon regenerate. Any one of these characteristics would make the care of these substances well worth trying.

Thus ends the article, and it means a great deal as the author has evidently had a large experience. With the syphilitic ulcers he uses blue ointment base and 5 to 8 per cent of scarlet red. The age of the patient makes no difference. Syphilitic treatment—30 grains of potassium iodide three times a day in water after meals and 1-12 grain of corrosive sublimate with each dose may be given where there is a positive Wassermann or a clinical history of syphilis. The ulcers in nine cases out of ten are well in three weeks under this treatment it the ulcers are due to syphilis.

Davis finds painful ulcers suffer less pain under scarlet red dressing than with the use of any other.

In second degree burns the ointment may be used as soon as the blisters have been cut away. In third degree burns wait until granulations have started.

If the skin when newly grown by scarlet red is dry and scaly apply olive oil or vaseline.

Theirsch and Reverdin grafts are sometimes much thickened after early scarlet red dressings, but the thickening disappears in a few weeks.

Scarlet red gauze is prepared by saturating gauze with a 4 per cent or 8 per cent alcoholic solution of scarlet red and allowing it to dry.

Dusting powders of scarlet red are 4 to 8 per cent strength to boric powder. Even a thin sprinkling of the pure red powder may be used a few seconds without irritation. Scarlet red or its pure component amidoazotoluol used dry with boric acid as above, dries out the wound rapidly with the formation of a tough scab under which the healing takes place.

There seems little or no difference in the action of the commercial scarlet red and its active component amidoazotoluol as tried by Davis. Scarlet red of the commercial type costs 60 to 70 cents a pound, enough for a lifetime; the pure component is, of course, more expensive. All the oinment the writer has used, given away, or made in my treatment room by myself in the Bobb's Dispensary Clinic of the Indiana University School of Medicine was made of the commercial scarlet red. I sent samples of the cheaper red to Dr. Davis and also of the Biebrich red—(50 cents to $1.00 an ounce) and in answer he told me they both served the purpose as well. Other dye stuffs also produce good results.

In using these ointments, gauzes or powders, call attention of patient to the red color, and the red urine, if much is used and see them daily for re-dressings and examination.

TECHNIC.

Cleanse the wound with boric acid or salt solution and dry. Peroxide of hydrogen may be first used to beat down unhealthy granulations. Nitrate of silver stick or acid nitrate of mercury will keep down exuberant granulations of the "proud flesh" type—and so will rubbing with a bit of gauze. Dr. Davis advocates tincture of iodine, U. S. P., after the silver nitrate, or on alternating days as a powerful and rapid method of cleansing granulations.

Use eight per cent scarlet red with balsam of Peru ointment as a base, or blue ointment, or iodoform ointment. Scarlet red itself has no antiseptic qualities; the above ointment bases have, and

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they may also be used for the alternating days. An eight per cent ointment should be worn 24 hours and the next 24 hours the bland ointment is applied. The doctor or nurse does the work each day; a capable patient may be taught to do the dressing himself.

Put the bland ointment around the ulcer up to within one-fourth of an inch of the ulcer edge. Spread the scarlet red on old line perforated and apply to the wound for half an inch, or over the whole surface in small ulcers or burns. Put on third, a light sterile gauze dressing secured by a roller bandage. A four per cent red is strong enough on partial skin grafts 48 hours after grafting. It stimulates the wound edges and the grafts themselves.

Finally, give Dr. Davis's rules a fair and full trial. The 50 papers he cites are on the whole enthusiastic in tone. Only three men report any bad results and all of these were in ear cases. It has been used with good results in corneal ulcers. Old age and great debility do not seem to have any deterrent effect on the stimulating power of scarlet red. The skin edges will grow even when there is a slough in the central wound. Skin is skin, and it grows whenever it has a chance as has always been its histologic habit and physiological purpose as a body protective. It was these very properties of this group of analine dyes that led to their use and healing power in ulcers. And the skin formed is claimed to be good, sound, lasting epithelial layers. No one has claimed that the glandular structures, sebaceous follicles, hairs, or sweat apparatus can be restored. That is unfeasible even in transferring pieces of good scalp—these organs all die out.

A skin wound is healed when it is filled up with connective tissue and covered with a red glazed epithelium. Scarlet red seems to hasten this process more than any other drug that has been applied.

As to the use of the gelatin paste laid on with cloth—the value of this has been attested by many in the healing of leg ulcers attenuated with edema and swelling. The patient should be in bed two days. The feet should be elevated for a few hours and the swelling reduced by gravity, by diuretics, by catharsis, by strengthening the heart action.

Then the paste may be laid on. A window may be left over the ulcer and it may then be treated by the scarlet red ointment according to the detail given above. The writer has used the paste to prevent the formation of ulcers with great success. The ulcers are usually started about the ankles by scratching. A carbolized paste changed every two or three days, prevents the scratching and formation of ulcers. And it gives great comfort to the patients. The writer has sent patients to New York and back on business trips with the paste on their legs to the knees—not to be removed at all until back home again.

Its uses in dermatology are numerous—in pruritus, in dry eczema, in ulcers as described above. The cost is moderate. Any druggist, doctor or housewife should be able to make it.

The writer will send his writings on the use of this paste to any physician who may desire to use the paste.

A. W. B.

CHRONIC ACETANILIDE POISONING.

Describing a Definite Symptom Complex As a Result of Its Continuous Ingestion.

Also Considerations on Chlorate of Potash Poisoning.

Dr. H. C. Gordinier of Troy, N. Y., read this paper, the conclusions which he drew from his study of the subject being as follows: 1. Chronic acetanilide poisoning was productive of the following perfectly definite and easily recognized symptom complex—chronic cyanosis, cardiac insufficiency, a distinct blood-picture showing profound disorganization, and definite renal changes. 2. The acetanilide habit was much more common than was generally supposed, and

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enslavement by it was comparable with or worse than that by opium or alcohol. 3. Acetanilide had a special predilection for the cardiovascular system, acting as a virulent hemolytic agent.

Dr. C. E. de M. Sajous of Philadelphia said that in his experience cases of acetanilide addiction were not so difficult to manage as those of opium addiction. He called attention to the constriction of the arterioles produced by the coal-tar products, as demonstrated by experimentation, and expressed the opinion that this was the chief cause of the cyanosis.—Medical Record.

Dr. Theodore Potter of Indianapolis, has a remarkable case of acetanilide habit which he will report. The hemolysis from this drug is not so much to be feared as that from chlorate of potash.

Dr. Scherer of Indianapolis, treated a girl who died in 48 hours from eating through the day a drachm of chlorate of potash tablets for a mild sore throat.

Dr. J. T. McShane had a similar case, dying in three days. Dr. Potter also had a case which was cyanosed and passed a smoky urine, but recovered. Austin Flint, in early editions, advocated large doses of chlorate of potash for pulmonary tuberculosis as a source of oxygen; he abolished his teaching later as the results above noticed must have occurred.

All these findings above were reported several years ago in this Journal and notably the case of the Davenport, Iowa, physician, who to help out a New Jersey confrere with a chlorate of potash malpractice suit to defend, took a half ounce himself to show how harmless chlorate of potash is, but died from the effects before summing up the evidence.

Acetanilide is not as dangerous a drug as chlorate of potash. Besides the latter is of little or no value as a mouth wash. A two per cent solution of chloral hydrate in alcohol, ounce one; glycerine, ounce one; and water to ounces six, used as a gargle or a spray is far better for a syphilitic sore throat as it is highly antiseptic and anesthetic. It is advocated by the German clinicians highly. The writer has used it in a whispering case of recent syphilis and the patient was at once relieved, able to talk and swallow readily. Salvarsan cured his throat in two days, and now with the use of salicylate of mercury injections every ten days in the gluteal muscles he has a negative Wassermann reaction.

Acetanilid compounds came into general use with the advent of the grip in the United States and was of great value where intelligently used. The first epidemic of grip was a joke; it was a two days affair with racking pain, high fever and often delirium. It was highly contagious. Later we had the bronchial and pulmonary type, slaying old people by the thousands and proving to be the most deadly epidemic that ever swept the earth in modern historic times—more general and fatal than the syphilis of the early fifteenth century, and only to be compared in its wide diffusion and fatality with the black plague and the smallpox. Forty years had passed since the "Tyler Grip" which Dr. P. H. Jameson described so graphically before Europe and America were again in the throes of this world-sweeping disease. Syphilis, bubonic plague, yellow fever, malaria, and last of all, typhoid fever are under absolute control; their causes are known and remedies or prevention are at hand. No civilized army will ever suffer again from these diseases. But the grip may reappear at any time and as yet there is no definite etiology or efficient treatment.

Chlorate of potash has gone into the stagnant sea of drug rubbish. Acetanilid is a clumsy weapon, but like opium is safe where properly and intelligently employed.

A. W. B.

THE INTRODUCTION OF THE OPHTHALMOSCOPE INTO THIS COUNTRY.

To the Editor:—In "A Tribute to Herman Knapp," you state editorially in The Journal, May 20, 1911, in substance that Dr. Knapp first introduced the ophthalmoscope into this country in 1868. This

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is erroneous. Whatever credit is attached to the first introduction of that instrument into this country belongs to the late Dr. E. Williams of Cincinnati.

In 1852, Dr. Williams determined to devote his life to the specialty of ophthalmology and went to Europe to perfect his education along that line. Just at that time the ophthalmoscope first came into use and Dr. Williams had the rare good luck to be able to study its uses along with Des Marres, Graefe, Arlt, Jaeger and others in Germany.

Early in the year 1854, he introduced the ophthalmoscope into London. At that time this instrument was unknown in England, so far as its uses were concerned. While in London, Dr. Williams wrote and published a full account of the new instrument in the Medical Times and Gazette, July 1, 1854. This article was the first ever published in English on that subject. The heading was: "The Ophthalmoscope; the Principles on Which it is Based—the Manner of its Application—and its Practical Advantages; with a Report of Some Cases."

I have a copy of this article. The description of the instrument, simple as it was, was very complete and the report of the three cases of retinal detachments would be practically up to date now, except that he called the cases "dropsy of the retina." The old English writers (Mackenzie and Lawrence) quoted extensively from this article in their books, published soon after the article appeared.

In the spring of 1855, Dr. Williams returned to Cincinnati and brought with him the first ophthalmoscope ever brought into this country, and from that time on he used the ophthalmoscope whenever he had occasion.

When I went to Cincinnati in the fall of 1860 to begin the study of medicine, Dr. E. Williams, my uncle and preceptor, and the first educated man in this country to make a specialty of ophthalmology, was using the ophthalmoscope right along and had been doing so ever since the spring of 1855.

From the above you can readily see that Dr. Herman Knapp did not introduce the first ophthalmoscope into this country.—A. D. Williams, Bedford, Ind.

(Dr. J. L. Thompson of Indianapolis, and also Dr. J. O. Stillson were students of Dr. Williams and would easily have corrected this error. Dr. Williams was a great credit to the medical profession and his work a blessing to humanity. The correction was in the Association Journal.)

SIGNIFICANCE OF FEAR IN MENTAL DISEASES. REPORT OF A CASE WITH CLAUSTROPHOBIA.

Dr. Max A. Bahr physician to the Central Hospital for Insane at Indianapolis, has an excellent article with the title above in the Medical Record of June 15th of which we present the following Record abstract:

In mental diseases fear may occur as an emotional state or with phobias connected with compulsory ideas. It may be joined with a painful feeling of oppression about the heart, constriction about the neck, or uneasiness in the abdomen. Localization of fear may be determined by accidental sensations of pains which exist, and are connected with the phobia. Fear exerts an influence on striated and unstriated muscles of the body. It manifests itself in movements of fear, such as rubbing of the hands, and to-and-fro movements of the body or limbs. It influences the peripheral circulation, the arteries undergoing contraction, and the heart becoming accelerated, irregular, and less forcible. Fear causes secondary delusional concepts. Absurd acts are committed under the impulse of these fears; women fear dirt, contagion, and infection. The common fears are claustrophobia, agraphobia, astraphobia, monophobia, pathophobia, mysophobia, etc. These are not normal fears based on actual experiences. They are groundless, and of intracerebral and not extraneous origin. Neurasthenic symptoma are wanting in these patients. Hereditary taint is frequent in these patients. The form may begin in childhood, or at puberty. The prognosis is unfavorable; usefulness

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is impaired, and suicide is not uncommon. An interesting case is reported.

A. W. B.

KEEP SOBER UNTIL YOU ARE THIRTY-FIVE.

Our collaborators have frequently sent items concerning Dr. Benjamin Rush for publication but his temperance views have evidently escaped notice. His essay on "Inquiries into the Effects of Ardent Spirits" has its influence and it was he who gave the advice, keep sober until you are thirty-five lest you contract gout.

The Saturday Evening Post for Sept. 2, has resurrected some facts of a century and a half ago. It says that he wrote temperance sermons and has sometimes been regarded as the founder of the modern temperance movement. He urged that wine or spirits should never be given to children. Students should shun them and he recommended their avoidance by all persons under thirty-five years except in case of certain ailments. The Post further says that to show "the dreadful consequences of excess in drinking" he describes a gentleman who is so affected with gout that he cannot leave his bed The following comment is made:

Possibly that was the beginning of the modern temperance movement. Most reforms begin that way. Somebody ventures to suggest, for example, the working factory children, eight years of age for fourteen hours a day is really not quite right; thirteen hours for those under ten would be better. Our tentative fingér-pointings toward some reforms today will certainly strike our great-grandchildren as Doctor Rush's advice to keep sober until you are thirty-five, lest you contract gout, strikes us.

S. E. E.

SOME THINGS ABOUT DETROIT.

Detroit is a beautiful city and there is but one Belle Isle in all this country; this may be accounted for by the efficiency of the park system. Indianapolis is on the way to such conditions. To boast of half a million of inhabitants and the absence of a City Hospital seems strange. The doctors are in the first rank, some of them I know personally. Harper, Grace, and other hospitals are commendable but it seems as if the city of Detroit should own one. There is another hospital now contemplated which in all probability will be excelled by few if any others and the moving spirit in this seems to be Dr. William F. Metcalf who was president of the Detroit Academy of Medicine in 1909. He is a man who knows how to do and does it. The successful outcome of this new venture (and I predict that there can be no such word as "fail," in the vocabulary of its supporters,) will reflect credit upon the members of the medical profession even beyond the domain of Michigan. The trustees will not be physicians and furthermore politics will not enter into the management. Dr. Metcalf who is a member of the finance and building committee, says that the plans and specifications are now in an eastern city for final inspection. Three important things are assured; the purchase of twenty acres of ground, money to erect the buildings and men to manage the affair who know how to do things. All this may be said to the credit of Detroit. It demonstrates the thrift, energy and progressive spirit of her people, and yet it does seem that in addition the commonwealth should own and conduct a hospital.

S. E. E.

Even the solemn and serene cemetery of the Moravians at Bethlehem supplies an interesting addition to the curious epitaph collection in the following, which is cut on a stone over the grave of an Indian: "In memory of my dearest son, James McDonald Ross, eldest son of John Ross, principal chief of the Cherokee nation, died in St. Louis, November 9, 1864. His corpse was transported by Adams Express to Bethlehem and interred at this sacred spot November 22, 1864, age fifty years, twenty-nine days."

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ABSTRACTS, EXCERPTS AND GLEANINGS FROM EXPERIENCE IN PRACTICE.

Furnished by Our Collaborators.

ACUTE POLIOMYELITIS. BULLETIN OF THE INDIANA STATE BOARD OF HEALTH.

During the four years, 1903 to 1907, in Norway and Sweden there occurred 2,164 cases, with a mortality rate of 13.8 per cent., while a large number of children and adults were left with paralyzed extremities. Dr. Harbitz in his report of this epidemic stated: "The disease is plainly contagious and spreads along lines of communication."

In the summer of 1907, New York City was visited by an epidemic in which 2,500 cases were reported. At the same time there occurred two small outbreaks in northern Michigan and Wisconsin, each in communities that had received immigrants from Norway and Sweden. In the summer of 1909 there was an outbreak in Nebraska, in which 1,000 cases occurred. Epidemics have occurred in Iowa, Massachusetts, California, North Carolina, and the disease now exists in greater or less extent in nearly every northern State. It is estimated that 100,000 cases have occurred in the United States since 1905, of which two in ten have died, and six in ten have been crippled.

Last year in Indiana we estimate no less than 300 cases occurred in many sections of the State, with sixty (60) reported deaths and at least 150 cripples. Already this year a number of cases have been reported, with three deaths in April, and 7 in May and others in recent months.

The literature of Epidemic Paralysis is only now being written, and but little dependence can be placed upon descriptions given in text-books of former years. Especially should physicians avoid trying to make all cases conform to text-book descriptions, as many border-line cases (mild cases) will be found in epidemic outbreaks. These mild cases, so called, are just as infectious as the more severe cases; in fact, are often a greater source of danger to others because of not being considered serious. The exact nature of the infective agent is yet to be learned, nor do we know how the infection is carried from one person to another. There are some reasons for believing that it may be dust-borne, since sprinkling has seemed to check the spread of an epidemic in a given neighborhood. There is also evidence that the disease can be carried by a healthy person from an infected center and given to another in a region far removed. Experiments have shown that the secretions from the nose and throat are infectious, and infection probably takes place through the mucous membrane of the digestive and respiratory tracts. This much seems certain: The infection is the disease, no matter what variation may be manifest in the clinical symptoms.

Among the more common early symptoms of the disease may be noted: Anorexia, vomiting and diarrhea; fever, sometimes reaching as high as 105 degrees; in some cases angina, tonsilitis, bronchitis or even broncho-pneumonia. In other cases, nervous symptoms predominate—torpor, somnolence; pain, which may be severe, in the joints, limbs, head, neck, etc. Fever, pain and sweating are symptoms common in the majority of all cases. Sometimes there are early sphincter symptoms, obstinate constipation or retention of urine. Frequently there is the history of a fall, so that often the paralysis or the fatal illness is attributed to the fall. This is not true: The fall is a result, not a cause. A child poisoned by the infection, with the resulting incipient motor paralysis, stumbles and falls. Unconsciousness, convulsions and paralysis follow from the infection, not from

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the fall. The paralysis appears suddenly in from one to three days after premonitory symptoms, and may involve the muscles in any part of the body. In many atypical or abortive cases paralysis does not occur. It must be borne in mind, however, that even when paralysis does not occur, the cases are infectious and capable of communicating the disease. In recent epidemics the milder cases have outnumbered those paralyzed, by a ratio of two or three to one. And it will be a distinct advantage in epidemics to consider every case, however mild, occurring in the course of an epidemic, as a case of infection from which the disease may be transmitted to others.

The period of incubation has not been definitely determined. In monkeys experimentally inoculated, the more common period is from 7 to 15 days. In the human being, approximately from 3 to 10 days is generally accepted as the most usual period, but great variations may occur, cases having occurred as late as 3 weeks following exposure.

The positive diagnosis depends upon the presence of paralysis, which is distinguished from other paralytic conditions by exclusion. The diagnosis is not difficult in typical cases, but may be doubtful in mild cases. In mild cases without apparent paralysis, fever, pain and sweating, with absence of reflexes following the febrile or other disturbances, should be noted, especially when such disturbances occur in relation to known cases of the disease.

During the acute or active stage of the disease all exercise or violence in handling the parts affected should be avoided. The natural disposition is to have the patient walk or move the paralyzed arm at frequent intervals in order to test the extent or progress of the paralysis. This should be avoided, on account of the liability to increase the inflammation of the nerve fibers in the cord. Even massage of the affected muscles is liable to cause spasmodic contractions of the muscles and thus aggravate the trouble. The active state is over usually in a few days, after which the efforts should be directed to stimulating and bringing back to normal the action left to the affected muscles. In obtaining this result, massage, and especially voluntary use of the affected muscles, are most efficient. Since the virus can be killed experimentally by a 1 per cent solution of peroxide of hydrogen, a gargle of this solution is recommended to be used by the patient and other members of the family.

Every known method for preventing the spread should be enforced.

1. The case must be completely isolated except for necessary attendance.

2. All utensils that have been in contact with the patient's mouth must be immediately disinfected.

3. All secretions from the mouth, throat and nasal passages must be destroyed by burning or by efficient antiseptics.

4. Give special attention to the physical condition of other members of the family, especially other children.

5. Everything about the house where a case has occurred must be disinfected.

6. Recognition by the authorities and the public of the serious menace of Epidemic Paralysis and the mutual co-operation of both in promptly combating the spread of the disease.

7. Report every case of Poliomyelitis immediately to the health officer having jurisdiction. He will immediately report such cases to the State Board of Health and blanks will be sent.

There is no serum or vaccine against Poliomyelitis. As the infection seemingly may be carried in dust, physicians should advise their families to protect against it as much as possible. On general principles advice should be given concerning methods to maintain high resistance. Keep children in good physical condition, without overexcitement or fatigue while they are well. Warn against juvenile parties, overeating, the use of tea, coffee, and other stimulants, and especially the use of fruit, vegetables and confections that have been exposed to dust. Advise plain living, extra bodily cleanliness, extra ventilation, extra rest. The great preventatives and the best treatment for this disease are

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Quiet, Rest, Good Food and plenty of outdoor air.

Dr. Flexner says in part, in his recent report on poliomyelitis:

We can now affirm with certainty that infantile paralysis is a disease due to a specific micro-organism, or germ, that attacks the spinal cord and, to a less extent, the brain, and by merely injuring or totally destroying the nervous tissues causes either a temporary or permanent paralysis of the muscles.

The specific cause or germ has been known for about a year and a half, during which time the disease has been under accurate scientific investigation through transmission to monkeys. Prior to this recent period almost no knowledge was possessed of the nature of poliomyelitis, and all our accurate knowledge has been gained since then through experiments on animals, and probably could not have been obtained in any other way.

No more convincing and impressive example of the value of the employment of animals in the elucidation of a serious and baffling disease than this could be cited. The germ is very minute and is probably below the limits of direct human vision. It has not yet been resolved by the highest powers of the usual or even by the ultramicroscope. It is capable of passing through the pores of the finest earthen filters.

The germ or infection agent is not known to reside anywhere in nature except in connection with human beings who either have had or have been in contact with some one who has had infantile paralysis, or in relation to some object in close association with patients suffering from the disease. It is established that the infection is spread by persons sick with the disease, or by some person suffering from the disease. Whether still other means exist for its transmission we do not know.

The chainlike connection between cases of infantile paralysis, affording the basis for this evidence, has been accurately determined in connection with epidemic abroad and in this country.

Discussing the possibility of other causes coming into the question of the spread of the disease, Dr. Flexner declares that insects that possess the power to migrate over a considerable territory that affect all classes of society, that abound during the period of greatest prevalence of the disease, and that do not wholly disappear at any season, should be the first to come under suspicion of the health authorities. The common house fly comes in for another round of abuse because it fulfills all the foregoing requirements.

"The most scientific, as well as the most humane way to deal with any disease is to prevent, rather than to attempt to cure it," continues the New York health authority. "Hence it is highly encouraging and commendable that so many states are making a determined effort to deal with epidemic poliomyelitis through prevention by requiring notification and quarantine of the disease."

Dr. W. F. King, acting secretary of the Indiana board, said he believed the negotiations now under way between the Indiana authorities and the New York institution relative to the investigation of the diseased parts of animals and human beings by the experts in the Rockefeller institution would culminate soon in the sending of all specimens available in Indiana to the Eastern experts.

Because a farmer near Crawfordsville went to the city after his farm had been quarantined by health officers when his child was stricken with poliomyelitis, Crawfordsville health authorities conferred with attaches of the State Board of Health and were informed that action could be brought against the man for such a breach of the health rules. Dr. W. F. King, acting secretary of the state board, said that the quarantine regulations in all cases are in the hands of the local health officers, and asserted that while there is little danger from contagion in "polio" cases, except to those who are thrown directly with the patient, it would be safest thoroughly to disinfect persons leaving a quarantined establishment.

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PYORRHEA ALVEOLARIS.

Williams in the May, 1911, Page 666 of the American Journal of the Medical Sciences, gives a very interesting report of cases of pyorrhea alveolaris treated with vaccine. He says Riggs disease is a condition that physicians have been prone to overlook or disregard. Dentists have on the other hand been awake to its importance because of its effect on the teeth. The process begins as an inflammation of the gums at its free border. It extends with varying rapidity to the structures along the root of the teeth.

The bony alveolar process is absorbed, the gum retracts, and the root of the tooth is laid bare. The tooth thus deprived of its bony support, becomes loose and ultimately may fall out. In this manner teeth that are perfectly sound are lost. Deep in the pocket calcium salts are formed on the root of the tooth as a scale that can be scraped off only with great difficulty.

The symptoms are many—the discharge of pus, the looseness of the teeth, and pain which may be excited by contact with heat or cold, or by the act of chewing. Sometimes the pain is nearly constant and it may be referred to other branches of the fifth nerve, as a trifacial neuralgia. The pus which flows into the mouth is very foul and the breath has a far-reaching odor of putrefaction.

The dental treatment of the disease which consists of thorough cleaning of the mouth in general and more particularly in scraping the calculus from the roots of the teeth with great care and patience on the part of the dentist and more or less severe pain on the patient's part is very unsatisfactory. A treatment that will check the destructive process more quickly and completely is a great desideratum.

Williams believes that a chronic, sharply localized inflammation such as pyorrhea is, seems peculiarly suited to treatment with bacterial vaccines. Beebe of Boston, has reported seventeen cases treated with vaccines, with very good results.

Eyre and Payne of London, also reported quite successful results in the treatment of thirty-three cases of unusual severity.

All of these physicians made cultures from the infected gums, isolated and identified the more prominent organisms, and determined the patients opsonic index to the various bacteria isolated from his mouth. He gives a detailed report of eight cases treated with autogenous vaccines, who were entirely cured. He says these were all intractable cases of long standing and had been carefully treated by dentists. His report is a confirmation of the value of autogenous vaccines in suppurative conditions. While I have had no experience in the treatment of this disease with vaccines, I can say that the use of autogenous vaccine has been very satisfactory in my work. I have been told by dentists that treatment did no good in Riggs disease, but it seems that a remedy is now at hand that will not only relieve but cure "the most common disease in the world."

T. C. K.

MEMBRANOUS PERICOLITIS.

Crossen of St. Louis, in the July, Surgery, Gynecology and Obstetrics presents an article entitled Membranous Pericolitis, with a report of several cases. He says: "Sometimes when we operate for serious symptoms supposed to be due to appendicitis, we find that the appendix is practically normal. Occasionally the trouble which was supposed to be appendical is found to be adnexal, and vice versa, occasionally the trouble which was supposed to be adnexal is found to be appendical."

It is not with either of these conditions that he treats in this paper. He inquires, "Suppose it is found at operation that the troublesome symptoms are due neither to the appendix nor to the adnexa—then what?"

In some of these cases the deceptive disturbances he believes are caused by an abnormal condition about the cecum and ascending colon, which condition has been designated by Dr. J. N. Jackson as "membranous pericolitis". He says they

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are troublesome, and therefore interesting in two particulars—first in regard to diagnosis and, second in regard to treatment. He believes the clinical recognition and correction is undoubtedly important, and marks the difference between success and failure in the operative treatment of these patients.

Case 1, in his report, was a woman, age 40. For four years the patient had pain in the right lower abdomen, coming on in attacks lasting three or four days. Pain was not associated with menstruation and not accompanied by any decided pelvic symptoms.

She had been constipated all her life, but this condition had increased since the onset of painful attacks. Examination revealed tenderness all over the right lower abdomen, extending down into the adnexal region and upward along the ascending colon, most marked, in the appendical region. He diagnosed the condition as chronic appendicitis, either alone or associated with an adnexal lesion.

At operation the appendix was found practically normal, and the right adnexa showed nothing to account for the symptoms. Investigating the cecum further, in the endeavor to find some cause for the disturbances which had rendered the patient an invalid, he noticed what appeared to be some old adhesions on the cecum some little distance above the base of the appendix. A small part of the omentum was found fastened here by an adhesion. He was able to demonstrate clearly to the assistants and visitors the veil-like membrane, with its longitudinal vessels, overlying the upper part of the cecum and the adjacent portion of the ascending. The colon was by the membrane, restricted and immobilized sufficiently to interfere with peristalsis, and to cause more or less difficulty in the passage of gas and feces. The membrane was peeled off up to the abdominal wall and excised. The appendix was also removed. Five months after the operation the patient was doing well. Her digestion was improved but she still had attacks of pain in the right side at times. These pains were less frequent than before the operation, but the same in character, and he thinks are due to gas distention of the cecum. This brings up the question as to whether removal of the membrane is sufficient to effect a cure in these cases.

He reports two other cases in which this condition was found. In each case the appendix was practically normal but an extensive was found which bound down the cecum and colon.

He says the distinctive symptoms of these cases develop from two factors: (1) interference with the peristalsis of the colon and (2) gas distention of the cecum. The pains, though coming in attacks somewhat like appendicitis or salpingitis, present the features of pain from distention rather than from inflammation.

That is, there is no fever, there is not the acute disability caused by peritoneal inflammation, there is not the strictly limited point of tenderness that comes with an inflammatory focus. The pain and tenderness are more or less diffused throughout the lower abdomen, there is decided gas distention with the attacks of pain, there is a history of the trouble beginning gradually and increasing persistently for one or more years, and there is a history of chronic constipation for many years before the onset of the distinct painful attacks.

This article of Crossens is valuable to every surgeon, as nearly every surgeon has operated cases diagnosed as appendicitis and at operation did not find the condition of the appendix accounted for the severity of the symptoms.

Further investigation along this line will undoubtedly be of value to every man doing this line of work.

Jackson called attention to this condition, which explains to every surgeon why some of his appendectomy patients still complained of pain, and will make him more careful in the future to investigate the condition of the cecum and colon.

T. C. K.

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SIMPLE METHOD OF PREPARING THE SKIN FOR SURGICAL OPERATIONS.

By E. H. Beckman, M. D., of Rochester, Minn.

A little over a year ago one of our staff, while visiting clinics in Italy, saw a method of preparing the skin for surgical operations in use in the clinic of Dr. Bastianelli in Rome, which we have used continuously since that time and have found simple, economical and effective. It is as follows:

The method of preparation consists of applying two solutions to the dry skin. The first solution is composed of one part of iodine crystals to a thousand part of benzine. Solution No. 2, consists of three and one-half per cent. tincture of iodine made by diluting the ordinary tincture one-half with alcohol. If it is necessary to shave the field of operation before preparing the skin, this should be shaved either dry or using benzine so that no water is absorbed by the cells of the tissues. Or, if desired, the field of operation may be shaved some hours before. Solution No. 1 is painted over the field of operation with a piece of gauze, simply rubbing enough to remove all dirt and scales from the skin. All the benzine should be allowed to evaporate, leaving the skin absolutely dry before solution No. 2 is applied. Solution No. 2 is then applied by painting over the field of operation with a pledget of cotton or a piece of gauze, saturated with the tincture of iodine. One coat of each solution is sufficient.

We have found this method of preparing the skin suitable for all classes of cases. The only type of case in which we do not use it is in exophthalmic goitre, where it is contraindicated on account of the iodine. It is simple, easy to apply, inexpensive, and, so far as antisepsis is concerned, as efficient as any method we have ever tried.

It is a particularly good method of preparation for emergency cases, especially cases of injury to the hands or arms in persons who have been working in grease. If it is desired, one can have in the emergency-room two vessels containing the above solutions. The injured part can be immersed in solution No. 1 and allowed to dry, and then immersed in solution No. 2 after which the patient is ready for operation.

After having used this method of preparation in all classes of cases for more than a year, we can recommend it. Care should be taken not to let the solutions run down into the creases in the groin, for when they dry slowly the skin is blistered. The tincture of iodine should not be too old, or it may become irritating.

(The above from the Mayo clinics is another instance of the growing belief in iodine as an antiseptic.—Editor.)

RESTRAINING THE PASSIONS OF YOUTH.

It is hard for us to understand how our sexual hygienists would restrain the passions of youth. They enjoin continence upon young men. Might not one as well enjoin another not to grieve who has lost a loved one? Is one injunction any less absurd or futile than the other? Does not this sort of thing conduce to secretiveness and hypocrisy in young men concerning sexual matters? Can we have anything more than a pretense of continence in most normal young men? Speaking frankly, to which type would the young men who could be induced to follow the advice be most likely to conform: the namby-pamby or the manly? Don't mistake our feeling on this subject. We understand all about venereal disease and the other evils that hedge in sexual expression. We are only wondering whether manly young men can be hypnotized into continence and be made to resist special temptations or excitations who are possessed of an instinct so hard to subdue that Howard Kelly once said of it (before he adopted the conventional cant on this subject) that one might as well try to restrain wild horses with wisps of straw.

All of which reminds us of a remark credited to a witty English bishop. "Of course," he confided to a close lady

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friend, "there is no such place as Hell, but we must keep it a secret. It would never do to let the criminal classes know it." Perhaps continence should be enjoined only upon the "criminal" classes, which means onyone but ourselves. Who of us that preaches continence today was continent when young? Who of us that is not a latter-day Pharisee thanks God today that he was not as other men when young? Who of us sincerely preaches continence today that is not over fifty or possessed of a consort?

Let us have only the truth on this subject, even if it be that continence is injurious and, in normal young men, impossible of practice. Let us have the truth, even if the truth controverts conventional morality. Of what value is a morality that is founded upon false concepts? It may serve the purpose of theologians, but it can serve no honest purpose. Humanity ought to abjure all artificial standards. It cannot attain to the full stature which is its destiny until it does.

How owlish the years, our own early gratifications, our matrimonial adjustments and a little hypocrisy finally make us!

—Med. Review of Reviews.

PREVENTION OF VENEREAL DISEASES IN THE ARMY.

Major William H. Wilson, of the army medical service in the Philippines, reports splendid results in the prevention of venereal disease in soldiers who had been exposed. They ought to convince any reasonable person that venereal prophylaxis of the most thorough sort is perfectly feasible, not only in the army, but in civil life as well, could the public be educated properly on this most important subject.

Wilson required all the men who had been exposed to report immediately for treatment, or as soon after such exposure as expedient. A 30 per cent. calomel ointment was rubbed into the penis, with particular attention to the glans and sulcus, and a silver colloid solution was instilled into the urethra and retained for some time.

The prophylaxis was found to be most effective against gonorrhea. There were 90 per cent of successes. Probably the failures may be accounted for on the ground of late treatment. The ideal method, it seems to us, would be to instruct the men how to treat themselves, suitable packages being provided them. Nor can too much stress be laid, it seems to us, on the necessity of thorough cleanliness as an essential part of any prophylactic management of the venereal diseases.—Med. Review of Reviews.

COLLECTION OF 1,282 CASES OF CAESAREAN SECTION IN THE UNITED KINGDOM.

Dr. Amand Routh (Jour. Obstet. and Gyn. for the British Empire, January, 1911), presents an interesting discussion of a very large number of cases which occupies the whole of one number of 233 pages. In the appendix, each case is individually listed, and, in the first part of the number, the subject is discussed as to its indications, technique, complications and mortality. Like most British obstetricians, Routh advocates induction of labor in the treatment of contracted pelvis of moderate degree—above 8 c.m. In pelves the less size, Caesarean section is indicated. He maintains this position by statistics of various clinics where spontaneous delivery occurred in from 70 to 85 per cent. of all cases of contracted pelvis and by giving the results of a large number of cases of induction with a maternal mortality of less than one per cent. Induction of labor should be used by all who estimate the life of the mother higher than that of the child. He quotes the mortality of craniotomy, as from 7 to 16 per cent, that of pubiotomy from 4 to 6 per cent with a high degree of morbidity.

The history of Caesarean section in Great Britain is given and the various advances in technique are described in their chronological order. The mortality of 1,058 cases of Caesarean section for contracted pelvis, operated upon from

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1867 to 1910, was 9.7 per cent. In uncomplicated cases where the membranes were unruptured and careful vaginal examinations had been made, the mortality was 2.9 per cent. When many examinations had been made and the patient possibly infected, the mortality was 17.3 per cent.; of these latter cases, if examinations were frequent and attempts at delivery had been made with forceps, the mortality was 34.3 per cent. Eloquent testimony this of the dangers of Caesarean section except as a primary procedure and of the risk of attempts at delivery before doing the operation.

The mortality of Caesarean section for complicating fibromyoma was 16 per cent; for eclampsia 60 per cent; for placenta previa 14.3 per cent; for cancer of the cervix 24.2 per cent. The total mortality of 1,282 cases of Caesarean section for all indications was 12 per cent; but the study runs back to the pre-antiseptic era. The mortality of 711 cases, operated upon in the last five years for all indications of 8.1 per cent may be taken as the present death rate of Caesarean section in the British Isles.—Med. Review of Reviews.

ETHYL CHLORID ANESTHESIA.

H. C. Wood, Philadelphia (J. A. M. A., December 24), calls attention to the perils of the use of ethyl chlorid as an anesthetic. While the statistics would seem to indicate that, as regards mortality results, ethyl chlorid stands between ether and chloroform, but closer to the latter, this conclusion is unfair. The anesthesias by ethyl chlorid have practically been all of but a few minutes' duration, and the prolonged anesthesias, which have to be credited with many of the fatalities of chloroform and ether, do not here come into consideration. The comparison should be rather with nitrous oxid gas. If we compare the commonly accepted mortality for nitrous oxid, one death in 1,000,000 anesthesias, with the figures for ethyl chlorid, one in 6,000, the danger of the latter is evident. The safety of an anesthetic is, as Miller remarks, to be judged by the range between the amount required to produce unconsciousness and that required to kill, and also by the character of the signs which indicate danger. These latter are for ethyl chlorid, such as may be easily overlooked by any except an experienced anesthetist, and another danger is remarkable suddenness of the fatality when it occurs. Wood considers the use of this agent by untrained persons as hardly less than criminal.—Med. Review of Reviews.

THE ETHER HABIT.

The statement of Dr. John Hildreth, of Boston, recently published, in which he speaks of the prevalence of the ether habit in Boston, brings to mind the ether drinking habit so commonly found in Ulster County, Ireland.

Dr. Hildreth says: "I personally know of a number of cases of young men who use the drug. They take it in their rooms, and as far as I know, they do not drink it, but inhale it, either by using a cone or by pouring a little on a handkerchief. I have heard of some who are advanced in the habit, though I cannot conceive of anybody wishing to drink ether, on account of its taste. There is always the chance, also, of a fatal overdose."

The ether drinking habit of Ulster is, however, a more serious matter. In one district the local magistrates considered it important to demand special legislation, as shown by the action of the justices at the Petty Sessions held in Cookstown, County Tyrone, last year; they adopted the following resolution:

"We, as magistrates, assembled at Petty Sessions, Cookstown, which includes in its area a considerable district in which ether as an intoxicant is indulged in, pray the Chief Secretary to the Lord Lieutenant of Ireland to so amend the law scheduling ether as a poison as to make it compulsory on the chemist to keep a record of the purchasers and the quantities purchased, as is done in the case of many poisons, and, if practicable, to limit any one sale to a small quantity, as we have reason to believe it is pur-

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chased in considerable quantities and resold illicitly in certain districts."

Similar resolutions have been forwarded by magistrates in other parts of Ireland.

Dr. William Colwell, of Belfast, has made special inquiry into the question of ether drinking in Ulster, and finds that the habit is confined to an extremely limited area. It seems to be common within this district, but practically unknown outside of it.

The history of this peculiar habit is interesting. Dr. Colwell quotes from a report by Captain Welch, as follows:

"In 1848 a bad epidemic of cholera broke out in Glasgow; among those flying from it were two or three who had returned to Draperstown, their native place. With them they brought a cholera specific, which they found comforting; a doctor, knowing that the comfort proceeded from ether, laid in a cask; he made his fortune, and the habit began."

"From Draperstown it has spread in a line that follows the hills, say, from Newtonstewart to Coleraine, speaking broadly, and the ether is principally taken by hill men."

The true intoxication from ether occurs when the drug is imbibed. The amount needed to produce the effect varies with the individual from two drams to three ounces. The intoxication comes on very rapidly, and is marked by extreme mental excitement resulting in dancing, shouting, and gesticulating. The effect passes off within an hour and leaves the victim much depressed.

The effects of the prolonged use of ether are the same as those of chronic alcoholism.—Long Island Medical Jour.

THERAPEUTIC NIHILISM AND FETISHISM.

Therapeutic nihilism and fetishism are the two extremes which physicians avoid quite naturally—at least they try to. Yet it is well worth while now and then to see if we are not loading up with worthless opinions, for we still retain remnants of the fetishism of our ancestors, and, when we discover one drug worthless, are prone to deny efficacy to the others. All men are not liars, even if the Prophet said they were, nor are all drugs frauds. We must remember that superstition is the birth of science for it follows upon the first attempts of primitive man to account for things. Sequence of events naturally was taken as a relation of cause and effect and a few coincidences were accepted as evidence of universal law, so that the false idea became fixed. The ability to find causes is given to but few men, consequently discoveries are rarely made, though everyone seems to be on the search. It is quite natural to hold to what was taught us in childhood, so there is no mystery about the universal therapeutic fetishism of laymen. Men carry potatoes in their pockets to cure rheumatism and wear an iron finger ring for gout or a leather bracelet to prevent cramps.

Professional fetishism is therefore quite easy to explain. The physicians of the past mistook the *post* for the *propter* and taught us the error which we find difficult to abandon.

When we persist in holding to an opinion in spite of proof of its erroneousness we are only human. So it is quite essential to have our baseless opinions collected now and then. Dr. W. M. Barton published a dozen in the Jour. A. M. A., May 15, 1909, aand followed them with a dozen more about a year later. Herewith is his list of therapeutic fallacies:

1. Olive oil to dissolve gall-stones.
2. Valerian in hysteria.
3. Tannic acid for internal hemorrhage.
4. Alcohol and ether hypodermically in shock and collapse.
5. Colchicum to cure gout.
6. Anilin dyes as tissue disinfectants.
7. Epinephrin as a heart stimulant.
8. Potassium iodide for scleroses.
9. Chlorate of potassium for stomatitis.
10. Hypophosphites and phosphates in neurasthenia and adynamic states.
11. Lithium salts in uric acid diathesis.
12. Calcium salts for internal hemorrhage.

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13. Lead and opium wash in sprains.
14. Aconite internally in neuralgia.
15. Spartein as a cardiac tonic and substitute for digitalis.
16. Nitro-hydrochloric acid in diseases of the liver and jaundice.
17. Physiologic salt solution as a heart stimulant.
18. Nitroglycerine and amyl nitrite as heart stimulants in anesthetic accidents and shock.
19. Calomel as a cholagogue.
20. Ammonium chlorid as an expectorant.
21. Sweet spirits of nitre as a diuretic and diaphoretic.
22. The pepsin-pancreatin-diastase fetish.
23. Ergot as an internal hemostatic.
24. Old oil of turpentine in phosphorus poisoning.
25. Hydrated iodide of iron and magnesia in arsenic poisoning.
26. Iodium phosphate in phenol poisoning.

Although he has experimental and clinical proof on which to base his opinion, we are not at all surprised that he should be taken to task by conservatives. They have used these things or have seen them used since infancy and it is quite reasonable that they should be shocked at being told a certain drug did not accomplish anything which brick dust could not do.

The use of useless drugs is the paradoxical point we must consider before we take the plunge into nihilism. Civilized intelligent laymen are convinced that there is something to help them no matter what the disease, and in this they are no different from ignorant savages. The sick man is desperately uncomfortable and restless until something is done for him—he does not care what. The feeling of contentment from knowing that he is receiving aid, must have a tremendous effect in bringing that rest which is so essential for recovery, perhaps even quieting an overacting heart and reducing a fatally high blood pressure. We are quite sure therefore that the benefit many find in these useless drugs, though real, is of an entirely different kind than the doctors think—and that if we do succeed in abolishing them, a hundred years hence we will be using a couple dozen others in equally absurd ways and getting equally great mental effects. Why not acknowledge that these things have a use like the fake barometer which a liner's captain always kept in the saloon with the needle fixed at "fair," "for the comfort of the ladies." We need not be ashamed to use a bread poultice or lead and opium wash if that is the only thing that a patient needs to get rest—it is more than the barometer fixed at "fair."—Am. Medicine, July, 1911.

THE CLOUD.

I bring fresh showers for the thirsting flowers,
From the seas and the streams;
I bear light shade for the leaves when laid
In their noonday dreams.
From my wings are shaken the dews that waken
The sweet buds of every one,
When rocked to rest on their mother's breast,
As she dances about the sun.
I wield the flail of the lashing hail,
And whiten the green plains under,
And then again I dissolve it in rain,
And laugh as I pass in thunder.

I am the daughter of earth and water,
And the nursing of the sky;
I pass through the pores of the ocean and shores;
I change, but I can not die.
For after the rain when with never a stain,
The pavillion of heaven is bare,
And the winds and sunbeams, with their convex gleams,
Build up the blue dome of air,
I silently laugh at the my own cenotaph,
And out of the caverns of rain,
Like a child from the womb, like a ghost from the tomb,
I arise and unbuild it again.

—Percy Bysshe Shelley.

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SIR JAMES BARR ON THE MEDICINE OF THE FUTURE.

Under the title of "Preventive Medicine: the Medicine of the Future," the hopeful reader expects to read a fairy-tale of the time when disease will no longer exist, when the efforts of therapeutists to cure disease will have been entirely obliterated by the work of the hygienists and bacteriologists in the prevention of disease. It is, therefore, a rather interesting, if unexpected, relief to find Sir James Barr, in a recent number of the British Medical Journal, discussing this subject from what must be called an heretic standpoint. He admits, of course, that prevention is better than cure, but he scoffs at certain accepted methods; for instance, he has collected a large series of statistics on the relation of tuberculosis to insanity, and he draws the conclusion from this that the world today is not yet ripe for the complete disappearance of the tubercle bacillus. Today the tubercle bacillus is a sort of guardian angel over the proper development of the race; it kills off in large numbers insane patients, thereby reducing the death-rate from insanity, and preventing propagation of an insane people. In fact, "if you abolish the tubercle bacillus in Ireland it will certainly become a question of 'God save Ireland,' because if you do abolish the tubercle bacillus the insane and the defective-minded will go on multiplying until the race is a race of imbeciles."

It would not serve any purpose to go into detail on the rest of the argument. We will pick out a few sentences here and there. Of pneumonia, he says, "The disease is short and inexpensive, so that no one makes much out of it except the undertakers, who grow fat on the misery of others. The case mortality is high, but yet no serious attempt has been made to curtail its incidence." In this sentence Sir James forgets that work is done in other countries besides England. In Germany and America a tremendous amount of work is being done on pneumonia, both from the standpoint of prophylaxis and of cure. Incidentally, he does mention the very valuable (?) penumococcus vaccines in the prevention of pneumonia. He also speaks very strongly on the use of vaccines as an important part of preventive medicine in diseases in which certainly the present results do not warrant his statements.

After reading other sentences of this sort, in which bronchitis, pleurisy, rheumatic fever, diseases of the blood-vessels, heart and kidneys, diseases of children, myositis ossificans, and congenital hypertrophic stenosis of the pylorus in infants are discussed, one is left with the decided impression that Sir James Barr believes the prevention of diseases will be accomplished by attention to the calcium metabolism, and by the more general use of vaccines. Americans will hardly agree that the bacillus coli vaccine is often useful in the treatment of appendicitis, or that the science of inorganic metabolism is by any means advanced far enough to consider calcium or potassium or sodium the disturbing factor in disease. But as an unusual contribution to the literature of the day, and as an interesting piece of insular humor, we can highly recommend a close perusal of Sir James' address.—Inter-State Medical Journal, Aug, 1911.

SALVARSAN MILK.

Jesionek (Muench. med. Wochenschr., 1911, No. 22). Early in the history of salvarsan it was noted that syphilitic infants, if nursed by syphilitic mothers who had received salvarsan treatment, showed a rapid disappearance of all manifestations of the disease. If directly injected with salvarsan, on the other hand, they often died. Ehrlich endeavored to explain this observation by assuming that, in the latter case, the rapid destruction of the parasites caused so great a production of their endotoxines, that the child succumbed. In the former case, however, the antibodies produced, by the treatment, in the mother's blood, passed into her milk and caused a gradual cure of the infant's disease.

Recent observations by Jesionek speak strongly against this hypothesis. In the

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first place, chemical analysis of the milk of women recently treated with salvarsan invariably shows the presence of arsenic. It is therefore possible that the good effect of such milk upon the syphilitic infant may be due to the arsenic rather than to the hypothetical antibodies. In the second place, he reports 2 cases in which syphilitic infants nursed by recently injected syphilitic mothers, showed extreme exacerbation of their lesions, justifying the inference that endotoxines from the maternal spirocheta had passed into the milk and so into the child. This method of treating infantile syphilis is therefore not free from danger. These considerations led Jesionek to try upon a suitable case the effect of feeding the child with milk from a goat that had recently been injected with salvarsan. The effect was striking. Within a week the syphilitic lesions had nearly disappeared and twelve days after the beginning of the treatment no trace of the considerable syphilitic ulcerations was visible.

One swallow does not make a summer. Still in view of the facts that the milk of a syphilitic mother injected with salvarsan may be noxious, that the milk of human beings or animals injected with salvarsan contains arsenic in some unknown organic combination, and that such milk has been shown to exert a beneficial effect upon infantile syphilis, the method unquestionably deserves a trial. The technique is so simple as to be at anyone's command. A milch-goat is given 0.6 grm. salvarsan intravenously (a cow correspondingly more), and the milk is fed to the syphilitic child. If further experience demonstrates the value of the method, such milk, fresh or concentrated will doubtless become an article of commerce.—Inter-State Medical Journal, August, 1911.

THE TREATMENT OF RINGWORM.

Dr. D. W. Montgomery, San Francisco (Journal A. M. A., May 27), says that while the St. Louis Hospital at Paris is one of the oldest seats of medical learning in the world, it looks it in its antiquated buildings and backward administration in many respects. A notable exception, however, is its skin department, which is one of the best of the kind that he has ever seen. It handles an immense amount of clinical material and its surgeons are among the foremost in the world in this specialty. He specially mentions the clinic of Sabouraud and his treatment of ringworm by the X-ray. The methods are described in detail and some of the prescriptions employed are given, with full directions for their use. The X-ray treatment has some disadvantages. The difficulty of treating ringworm of the scalp with the ordinary methods lies in the thick coating of stout hair in which the fungus lodges, but with the affected area completely denuded of hair by the X-ray the disease becomes as easy to treat as if on the free surface of the skin. A rather heavy dose is required, however, usually for about fourteen minutes at 20 cm. The risk of causing an X-ray burn is therefore imminent. In Sabouraud's clinic it is said that they never have any unfortunate results, but other operators are not always so successful. The pastilles of Sabouraud which are used as control tests, as made in Germany, England and France, are not always uniform composition and their change of color when interposed in the X-ray may not always be a reliable guide. When an ordinary pyogenic infection of the scalp is associated with ringworm Alibour's lotion is an excellent remedy. It is composed of sulphate of copper 2 gm., sulphate of zinc 7 gm., camphorated alcohol 20gm., water from 1,000 to 2,000 gm. It is an excellent antistreptococcic as well as antistaphlococcic lotion, and can therefore be used in erysipelas, etc., with advantage. In conclusion, Montgomery speaks of the immense skin disease material passing through the hospital which is an embarrassment of riches, as inducing imperfect diagnoses.

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THE LIME LIGHT ON PNEUMONIA.

James R. Mitchell, Fort Worth, Tex., states that every aspect of pneumonia shows the value of calcium in this disease; the pneumococcus extracts calcium from the medium in which it grows and from the human culture medium as well. In this disease the elimination of calcium is increased in the urine and feces. Convulsions are caused by the poverty in calcium, and the convulsions of pneumonia are probably due to this condition. Hyperacidity is an invitation for chemical alkalies, and when hyperacidity occurs in the stomach in pneumonia one may suspect that there is a demand for calcium. Calcium is required for the action of lysins and opsonins, and the phenomena of leucocytosis. Gray hepatization, which is a process of contest against the penumococcus, is impossible without calcium. Edema of the lungs and collapse of the heart occur only when the coagulation time of the blood is delayed, as occurs with poverty of calcium. Thus the importance of calcium in pneumonia is shown. Rational therapeutics demands rest, and supportive treatment in this disease. Stimulation and antipyretics are useless and harmful, but calcium should be supplied through the administration of milk and lime water, and by calcium medication. The author treated in this way thirty-three cases, with two deaths. In the fatal cases the treatment had not had time to take effect.—Medical Record, August 5, 1911.

REPORT OF A CASE OF ANAPHYLAXIS.

W. S. Thomas and W. K. Terriberry, New York, relate a case in which a small dose of antitoxin was followed by marked dyspnea and cyanosis, all the respiratory mucous membranes being edematous. Cough and the expectoration of pinkish serum were present. The condition was so bad that preparations were made for intubation and the heart action almost stopped. The symptoms soon began to improve and were over in about six hours, but were followed nine days later by urticaria.—Medical Record, August 5, 1911.

A CASE OF EXOPHALOS.

In April, 1907, Worcester, England, Mr. Stanley Bott (The Lancet, April 29, 1911, p. 1134) was called to a case of confinement by a mid-wife. On arrival the baby shown him had a large peduncudalted tumor hanging from the umbilicus; the covering of the tumor was a thin transparent membrane through which the liver and intestines could be seen; he recognized this as a case of exomphalos and made preparations to restore the abdominal contents to their proper cavity. By the time he had summoned help and was ready to undertake the work the condition of the infant had become so precarious that it was decided not to interfere. The baby died about 12 hours later. On closer examination the whole abdominal contents were found to be herniating from a potent umbilicus of about the size of a flor, through which the vessels and connections of the viscera passed. Embryology (Keith's) teaches that the thin transparent membrane covering such tumors is the somatopleure, or belly wall, and that the condition is due to a failure of the bowel to migrate intra-abdominally at the end of the second month during the rapid extension of the lumbar and dorsal regions of the spine and the growth of the body walls. The mother in this case had not given birth to a child for a period of about 15 years. Her environment predisposed her to alcoholic excess.

W. W. V.

PROSTATECTOMY.

Amongst the surgical advances of this present century (Address in Surgery, the Lancet, July 29th, 1911, p. 291) the treatment of a large prostate by enucleation stands conspicuously prominent. The term "prostatic hypertrophy" is a misnomer, the enlargement being due to the adventitious within the substance of the prostate of distinct neoplastic structures, adenonatous in their nature, developed doubtless from the normal gland tissue,

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but as distinct from simple hypertrophy as the common adenoma of the female breast is from general mammary overgrowth. The development of these adenomatous masses we do not know; none of the many explanations offered quite fit the facts, but that they are of very common occurrence is certain. As visiting surgeon to the Birmingham Workhouse Infirmary I have access to an enormous mass of pathological material. Some years ago I removed post-mortem and carefully examined the prostates from a consecutive series of thirty men between the ages of 21 and 94 years, dying from various maladies. Three of the thirty were under 40 years of age, and all their prostates were normal; but of the remaining twenty-seven, five only were normal, twenty-two showing well marked adenomatous growths. The detail figures are interesting: Of six in the forties, five were enlarged; of three of the fifties, two; of eight in the sixties, six; of eight in the seventies, seven; one in the eighties and one in the nineties were both enlarged. Of normal prostates there were one in six in the forties; one in three in the fifties; two in eight in the sixties; one in eight in the seventies; and none above that age—that is to say, over forty years of age less than one prostate in five were normal, and over fifty years less than one in four.

Suprapubic and perineal prostatectomy each has its merits, and neither can claim to be the better operation for all cases. The suprapubic enucleation of a large soft adenomatous prostate from a man of moderate size is an ideal manipulative procedure—nothing more satisfactory in the whole field of operative work; but the enucleation of a slightly enlarged, tough, fixed organ from within the bladder of a bulky drayman is quite another business, and may be more easily and more satisfactorily accomplished by the perineal route. Each operation has its difficulties and its dangers, and in these matters there is little to choose between them. The suprapubic operative mortality is rather the higher in my hands, probably because the more serious cases have been dealt with by this method. The after-results of both operations are about the same. Usually the results of prostatectomy are excellent; in the majority functional restoration is complete, and the patient is eminently satisfied. In a fair number, however, marked improvement is all that can be claimed, while in a few disappointment follows. Impotence probably results, but the sexual function is not always abolished. Prostatectomy for carcinoma and tubercle has been disappointing.

W. W. V.

MISTAKES.

The address in medicine this year (The Lancet, July 29th, 1911, p. 281), before the British Medical Association, Birmingham, was given by a distinguished Scotch physician, teacher, author, on this subject; he began modestly by saying he was well qualified to speak to this subject, "for I have had a large and varied experience and—I have made many mistakes." It is not a question as to who makes and who does not make mistakes; it is only a question of who makes the most mistakes and the biggest mistakes; in view of the difficulties and perplexities that surround the work of a physician, it is only a wonder that he does not make bigger and more frequent mistakes than he does. Every one will allow that one learns from one's mistakes, as a rule more than from his successes, and when a mistake is made it should always be analyzed, and if possible, its cause ascertained.

Mistakes due to imperfect knowledge, to want of clinical experience, to erroneous observation, to inability to observe correctly, are most common in the early years of one's practice as a physician (here cases are cited in illustration.)

In the cases of experienced practitioners, *hurry*, and the incomplete examination of patients due to hurry, and hasty conclusions are probably by far the most common causes of errors in diagnosis. Another cause of mistakes is due to the fact that the information which we get from third parties is insufficient, inaccur-

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ate, or misleading. Again erroneous deductions and illogical conclusions are very common sources of mistakes. This is not to be wondered at when it is remembered that there is probably no faculty of the human mind which differs more in individuals than the faculty of judgment—the power of seeing things in their correct proportions, the ability to weigh correctly all the facts of a case and to draw the correct and logical conclusions therefrom. This statement finds ample illustration from the bench and bar where the judicial faculties are most highly cultivated,—different conclusions are drawn from the same facts. A good physician soon learns to be cautious in publically criticising the supposed mistakes of others, especially his neighbor physicians, especially about cases where his judgment may be warped or biased. This fact finds illustration when the physician undertakes to diagnose and treat illness in a member of his own family. "Finally, I have tried in these, I fear somewhat fragmentary and commonplace, remarks to bring before you some of the chief causes of our diagnostic errors and mistakes, and indirectly to point out that the only way to avoid diagnostic mistakes is, first, to gather carefully and correctly the data—the facts on which the diagnosis has to be based—by exhaustive and accurate clinical observation and examination; secondly, after these data have been obtained to weigh them impartially and judicially, taking all the facts into consideration, avoiding so far as possible, preconceived opinions, giving due weight to the symptoms and sensations of the patients as well as to the physical signs; and thirdly, to draw a logical and correct conclusion from the premises. If what I have said will stimulate some of you to observe your cases with greater thoroughness and interest, and will help you to avoid some of the mistakes which I myself have made, I shall be well content."

W. W. V.

LAST SURVIVOR OF BURNS DEAD.

The last surviving grandson of Robert Burns died recently at Glasgow in his eighty-fourth year. He was James Glencairn Thomson, the son of one of the three daughters of the famous poet, all of whom were named Elizabeth. This Elizabeth was Burns's daughter by Anne Park, and was born in 1791. She married John Thomson, a weaver, and lived at Pollockshaw, Renfrewshire. Their son James was called Glencairn probably after Lord Glencairn, for whose patronage Burns always expressed the warmest gratitude.

Born in 1828, thirty-two years after his grandfather's death, James became a weaver like his father before him. After the collapse of hand-loom work he took to calico printing. He never married. Nearly all his life he resided in the suburbs of Glasgow, and was a frequent guest at social gatherings, where his singing of Burns's songs was a feature. The old man's declining years were made more comfortable by the grant of a small civil list pension.

—N. Y. Times.

HER SECRET.

One day a pastor was calling upon a dear old lady, one of the "pillars" of the church to which they both belonged. As he thought of her long and useful life, and looked upon her sweet, placid countenance bearing but few tokens of her ninety-two years of earthly pilgrimage, he was moved to ask her, "My dear Mrs. S., what has been the chief source of your strength and sustenance during all these years? What has appealed to you as the real basis of your unusual vigor of mind and body, and has been to you an unfailing comfort through joy and sorrow? Tell me, that I may pass the secret on to others, and, if possible, profit by it myself."

The old lady thought a moment, then lifting her eyes, dim with age, yet kindling with sweet memories of the past, answered briefly, "Victuals."

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MEDICAL MISCELLANY.

BIG MEETING OF THE INDIANA MEDICAL ASSOCIATION.

September 28-29.

The officers of the Indiana State Medical Association confidently believe that the Annual Meeting, to be held at the German House, Indianapolis, Sept. 28 and 29, 1911, will be the biggest and best in all its history.

The scientific program comprises live, up-to-date papers on such subjects as Autogenous Vaccines, Surgery of Typhoid Fever, Salvarsan, Displacement of Abdominal Viscera, Difficult Labor, Infantile Paralysis, Treatment of Heart Disease, Conservation of Hearing, Gallbladder Infections, Uterine Fibromata, Exophthalmic Goitre, Fractures, Hernia, Pulmonary Thrombosis, Pernicious Anemia, Aseptic Surgery, Diet, Reflex Neuroses, Empyema, Adenoids, Toxemia of Pregnancy, Nervous Crises, Early Prostatectomy, Tuberculin, Syphilis, and Non-Tubercular Sacro-Iliac Disease.

In connection with, or supplemental to, these papers will be scientific demonstrations, including Lantern Slide Exhibition of X-Ray Skiagrams, Diagnosis and Treatment of Pyo-Thorax (demonstration on dissected cadaver), Widal reaction, Wassermann reaction, spirochetes, laboratory methods, administration of salvarsan, autogenous vaccines, etc.

On Wednesday, Sept. 28, at 9 p. m. (following meeting of the House of Delegates) the Indianapolis Medical Society gives a "Smoker" at the German House, to which all members of the Association are invited.

Visiting ladies are invited to a reception at the residence of Dr. and Mrs. T. C. Kennedy, corner of Irvington Ave. and E. Washington St., Wednesday, Sept. 27, at 8 P. M.

Auto rides will be given to visiting ladies, starting from the German House, Thursday, Sept. 28, at 11 A. M. and a luncheon at the Country Club at 12:30.

On Thursday, Sept. 28 at 7 P. M. the great "Medical Achievement Banquet" will be given in the big hall of the German House, for members and their wives and guests. The price of this will be $2 a plate and all desiring plates should notify Dr. E. D. Clark or Dr. J. F. Barnhill not later than Sept. 24.

It is expected that this will be the greatest medical banquet ever given in Indiana. Prominence will be given to some of the things our profession stands for and there will be lots of high-class fun. The speakers will be Dr. Harvey W. Wiley of Pure Food fame, Gov. Marshall, Rev. Frank Wicks, Senator Kern, Prof. Coulter, Dr. Emerson, the new Dean, with some cartoons by "Abe Martin," and letters from Senator Owen, Dr. Welch and Mededith Nicholson. Chas. W. Fairbanks may also speak.

Besides orchestral music it is reported that a strictly medical choir will sing some songs appropriate to the occasion.

The noise made there may be like the shot at Lexington that went round the world, and may assist the fights for Pure Food and Medical Progress..

Dr. Paul F. Martin, Chairman of the Clinical Committee, reports as follows:

Interesting Surgical and Medical Clinics will be held at the City Hospital Wednesday Sept. 27, and Friday, Sept. 29, immediately preceding and following the scientific session of the next annual meeting of the State Medical Association. Pathologic and Bacteriologic demonstrations will also be given at the City Dispensary in conjunction with the Medical Clinics Saturday morning, Sept. 30.

It is earnestly hoped that members of the Association will take advantage of this unusual opportunity offered them, and attend this part of the program in large numbers, as they can be given every assurance that they will be amply repaid for their time.

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SCHEDULE OF CLINICS.

City Hospital Amphitheatre.

Wednesday, Sept. 27.

1:30 P. M. Gynecological Clinic
Dr. O. G. Pfaff

(1) Abdominal Hysterectomy.
(2) Vaginal Hysterectomy.

3:00 P. M. Surgical Clinic.
Dr. John Oliver

(1) For Inguinal Hernia.
(2) For Cleft Palate.

Laboratory Building.

1:30 P. M. Medical Clinic
Dr. F. B. Wynn

(1) Cases Illustrative of Primary and Secondary Anemias with Considerations of Differential Diagnosis and Treatment.
(2) Cases of Infectious Disease in which the Value of Blood Examinations will be shown.

3:00 P. M. Dermatological Clinic.
Drs. Brayton and Erdman

(1) Presentation of cases:
Hicten Planus, Blastomycosis, etc.

Friday, Sept. 27.

Amphitheatre.

1:30 P. M. Genito Urinary Clinic
Dr. W. N. Wishard

Cases to be announced later.

3:00 P. M. Surgical Clinic
Dr. E. D. Clark

(1) For Goitre.

Laboratory Building

1:30 P. M. Nemological Clinic.
Dr. A. E. Sterne

3:00 P. M. Medical Clinic.

Saturday, Sept. 30.

Clinics by Dr. Louis Burckhardt.
Tubercular Reactions With Clinical Demonstrations and Complications of Typhoid Fever.

City Dispensary.

8:30 to
11:00 A. M. Dr. B. Erdman

(1) Intravenous Administration of Salvarsan.
(2) Demonstration of the Various Steps of the Wassermann Reaction and of the Spirochete Pallada by Dark Field Illumination.
Dr. Thrasher

(3) Medical Clinic.
Drs. Burkhardt and Garrett
Syphilitic Cases
Esophageal Diverticula

DR. PAUL F. MARTIN,
Chairman of Clinical Com.

CONVENTION OF AMERICAN ACADEMY OF OPHTHALMOLOGY AND OTO-LARYNGOLOGY IN INDIANAPOLIS.

September 25, 26, 27.

The program for the sixteenth annual convention of the American Academy of Opthalmology and Oto-Laryngology, which will be held in Indianapolis, Sept. 25, 26 and 27, is announced by Dr. John J. Kyle, president of the organization. A score of leading specialists will deliver addresses at the session, and it is expected that about 250 persons will be in attendance. The principal speaker will be Dr. Albert Gray of Glasgow, Scotland, who will come to America for the purpose of addressing the convention.

The Claypool Hotel has been selected as the headquarters for the society, and all convention sessions will be held there. Numerous entertainments are being arranged for the physicians who will attend.

LIST OF SPEAKERS.

The speakers and their subjects follow:

Dr. Albert Gray, Glasgow, Scotland, "The Problem of Ostosclerosis and Allied Conditions;" Dr. John J. Kyle, Indianapolis, the president's address; Dr. F. Park Lewis, Buffalo, N. Y., the vice president's address; Dr. F. M. Fernandez, Havana, Cuba, "Ocular Leprosy"; Dr. G. Sterling Ryerson, Toronto, Canada, "The Use of Radium in Ophthalmology"; Dr. Wendell Reber, Philadelphia, Pa., "Concerning Uveitis and Descemetitis in Particular and Its Probable Relation to Latent Nasal Obstructions"; Dr. Dean D. Lewis, Chicago, "Tumors of the Hypophysis and Their Relation to Acromegaly and Froelich's Syndrom"; Dr. J. A. Stucky, Lexington, Ky., "Ophthalmia and Trachoma

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in the Mountains of Kentucky"; Dr. E. C. Ellett, Memphis, Tenn., "On Cataract Extraction with Corneal Suture"; Dr. Lucien Howe, Buffalo, N. Y., "The Normal Lens as Figured in the Text-Books and as Seen in the Eye"; Dr. Samuel D. Risely, Philadelphia, Pa., "Some Surgical Experience in Wills's Eye Hospital"; Dr. B. C. Corbus, Chicago, "Ehrlich-Hata '606' in Ophthalmology"; Dr. Frank Carroll, Cedar Rapids, Ia. "An Accurate and Rapid Method of Refraction"; Dr. D. W. Greene, Dayton, O., "Ophthalmology"; Dr. H. H. Martin, Savannah, Ga., "Thrombosis of the Cavernous Sinus, With Report of Case"; Dr. Lafayette Page, Indianapolis, "Neoplasms of the Larynx"; Dr. William L. Ballenger, Chicago, "Acute and Chronic Labyrinthitis"; Dr. Richard McKinney, Memphis, Tenn., "Streptococcic Infections of the Throat"; Dr. Clarence W. Warfield, San Antonio, Tex., "Iodine as a Therapeutic Agent in Hay Fever, Asthma and Atrophic Rhinitis"; Dr. W. T. Moore, Huntington, W. Va., "Ear Diseases Due to the Bacillus Mucosis"; Dr. W. W. Carter, New York, by Mechanic Means and the Transplantation of Bone"; Dr. C. M. Miller, Richmond, Va., "The Histology and the Nasal Treatment of Acute and Subacute Suppuration of the Sinuses"; Dr. W. E. Murphy, Cincinnati, O., "Accidents in the Treatment of the Eustachian Tube"; Dr. M. A. Goldstein, St. Louis, Mo., 'The Topography of the Labyrinth With Lantern Slides"; Dr. Myron Metzenbaum, Cleveland, O., "Submucous Septal Operation"; Dr. F. P. Calhoun, Atlanta, Ga., "Results in Cases of Sinus Trombosis"; Dr. John McCoy, New York, "Some Complications and Terminal Lesions of Mastoiditis"; Dr. Harry Young, Burlington, Ia., "Visual Requirements of Enginement—Some Results of Agitation"; Dr. Thomas Faith, Chicago, "Some Surgical Means in the Management of Trachoma"; Dr. Charles Kollock, Charleston ,S. C., subject to be announced; Dr. John O. McReynolds, Dallas, Tex., "Cerebellar Tumor and Complete Optic Atrophy, Presentation of the Specimen"; Dr. Martin H. Fischer, Cincinnati, O., "Sodium Citrate in Glaucoma"; Dr. Wolff Freudenthal, New York, "Prognosis and Treatment of Tuberculosis of the Larynx"; Dr. Henry Hartz, Detroit, Mich., "The Lymphatics of the Nose and the Naso-Pharynx"; Dr. Henry B. Hitz, Milwaukee, Wis., "Anomalies of the Mastoid Process"; Dr. Wendell Phillips, New York, "The After Treatment of Radical Mastoid Operation With Special Reference to Packing"; Dr. Emil Mayer, New York, "The Treatment of Cicatrical Laryngeal Stenosis," and Dr. Lorenzo B. Lockard, Denver, Col., "The Principles of Operative Treatment in Laryngeal Tuberculosis."

The order of presentation of addresses has not yet been completed. Preparations for the convention are being made by Dr. Kyle of Indianapolis, president, and Dr. George F. Suker, of Chicago, secretary of the organization.

(The above will prove a great and successful meeting. Indianapolis has a strong leading in eye, ear, nose and throat work, with several authors and teachers. The general profession are also interested as it is more and more certain that the nose and throat are the avenues by which most of the serious diseases enter the human system.—Ed.)

DEATH OF A PIONEER, DR. WILLIAM BAILEY.

The death of Dr. William Bailey occurred at Louisville, July 17, 1911.

Dr. Bailey's life was marked by uninterrupted activity until a few nights before Christmas, 1910, when he sustained a fracture of a shoulder bone from a fall while walking to his aparments from the Tavern Club, where he had attended a medical meeting.

About a week after the accident Dr. Bailey suffered a slight stroke of paralysis, which affected his throat. In order that he might take nourishment special treatment was required two months. Though he was able to go about to some extent, his physical condition was gradually impaired, and on the morning of July 12 he was forced to remain in bed. The day after resolutions of sympathy

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were adopted at the meeting of the Kentucky Midland Medical Society.

Dr. Bailey was born November 4, 1833, at Bridgeport, Franklin county, which is near Frankfort. He was a student in the Kentucky Military Institute and, after graduating, was a member of the faculty one or two years. Then he came to Louisville to begin his life's work in the study and practice of medicine and surgery. On September 7, 1859, he was married to Miss Sue Owen, of Shelbyville, where he resided a year. He served as surgeon during the Civil War with the Ninth Kentucky Cavalry, Union army.

At the close of the war Dr. Bailey returned to Louisville, making his home here thereafter. He was one of the founders of the Hospital College of Medicine. After twenty-five years he severed his connection with that institution and began lecturing in the medical department of the University of Louisville. He gave up the chair he occupied a few years ago, because of his age.

For many years Dr. Bailey was actively interested in the work of the Kentucky State Board of Health, of which he was formerly president. For one year he was president of the American Public Health Association.

Four years ago the Medico-Chirurgical Society presented Dr. Bailey with a loving cup. At that time he had been practicing medicine half a century, and was probably the oldest physician in the city in point of years of service.

As Dr. Bailey's experience in his profession increased by years, he appreciated the revolution in theories and methods of treatment of disease and assiduously applied himself to the task of acquaintance with the most advanced ideas and efficacious practice. It is related of him that he never felt he should lecture an hour without reading an hour for each lecture, though he lectured for twenty-five or thirty years. At one time his eyes were affected and he had Mrs. Bailey read to him before he lectured. That his calling and his knowledge of medicine should be primarily a sphere in which to serve his fellowmen was a controlling principle in his life. Before he was injured he hardly missed an hour or day responding to calls.

Dr. Bailey was a leader in thought and experiment to ascertain more successful ways of combating yellow fever, and was one of the first physicians to hold the theory that yellow fever is caused by the bite of a mosquito.

DOVER, OF DOVER'S POWDER.

The picturesque type of medical man has passed away; he is a creature of the past. If we wish to resurrect him in our mind's fancy we can do no better than to read the life of Thomas Dover—he of Pulvis Ipecacuanhae compositus fame. If we can credit Smollett, the practitioners of Dover's day were, many of them, extraordinarily adept advertisers and grafters, though always in more or less ethical guise. Dover almost deserves relative respect, in that he actually became an avowed buccaneer, roaming the high seas in the most piratical fashion. Many of his confreres ashore were buccaneers as truly as he, pirates who cruised London town with the black flags of professional piracy stowed in the medical locker and flying hypocritically in their stead the stolen pennants of the little ethical brotherhood, they who guided themselves by the principles of Sydenham the revered.

Well, Dover's ship, the "Duke and Duchess," reached England in 1711 with £170,000 prize-money and with Alexander Selkirk ("Robinson Crusoe") as mate, Dover having taken the famous castaway off Juan Fernandez on the 2nd of February, 1710. The captains details of rescue read as romantically as Defoe's story itself.

Dover led the van in an assault on the two cities of Guaiaquil, and then sacked them.

Certainly a picturesque, romantic career. After he relinquished buccaneering he established himself in London as a practitioner. There he wrote "The Ancient Physician's Legacy—"for revenue purposes" only, for the spirit of the buccaneer was not dead in the old man, as

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"no occasion is missed either to blow his own trumpet, or to tilt a lance at his colleagues."—Critic and Guide, June, '10.

CORRESPONDENCE.

Bellevue Hospital.

New York, Aug. 10, 1911.

Dr. C. E. Ferguson,
Indianapolis, Ind.

Dear Doctor Ferguson:—I am a little negligent but I want to thank you for the letters you wrote for me. They helped me materially in getting a place this week. I took the competitive examination at the New York Lying-In Hospital and now an appointment for four months service beginning Oct. 1st. There were thirty-three in the examination for twelve places and Dr. Geo. D. Haworth, of my class, and I, both received October appointments. We both feel mighty good over it and must say that Indiana University Medical men show up very favorably with Eastern trained men.

We are getting some excellent work surgery, but no obstetrics at all.

Thanking you again for past favors, I am,

Yours fraternally,
John C. Irwin.

Hotel Imperial, 206 E. 13th Street.

New York, Sept. 2, 1911.

Indianapolis Medical Journal,
Indianapolis, Ind.

Dear Dr. Earp:—Of the many medical journals I am privileged to receive, yours is the one I think ought to have the benefit of the following which is a translation from the German:

"Justinus Kerner, the poet and Weinsberg physician, once made a long stroll with his children. A messenger, from a far away town, intercepted him. Kerner was requested in that letter to attend an urgent case immediately and to send a prescription back by messenger. Neither he nor the messenger had any writing materials with him, but, nonplussed, Kerner asked the messenger if he had a piece of chalk with him. He had. Whereupon Kerner wrote his prescription on the back of his sturdy companion, urging him to let no man slap his back and to go straight to the local apothecary to exhibit his back. Such was done. And the local dignitary, well acquainted with Kerner's chirography, filled out the prescription, remarking, incidentally, that he had never seen a prescription of Kerner's written as plain ly as the one in question.

Of course, the patient recovered and would unquestionably live to this day if he had not intermediarly died. Otherwise the story would have lost one of its good points—efficiency in an emergency."

Very truly yours,
HENRY RICHTER, Ph. D., M. D.

My Dear Dr. Brayton:—

Please accept my thanks for those kind words which as you know are better than coronets. My little letter was treated most kindly by my friends—even to the extent of an editorial in the "News" and extracts in the "Military Surgeon." I enclose a copy of the "Examined" bulletin by which you will see that I was elected Vice President of the American Association of Medical Examiners. This isn't a personal honor; the committee simply wanted some one from Indiana and they made me the goat. The Interstate Association of Medical Examiners voted to amalgamate with the American Association of Medical Examiners which was done and we elected Dr. Cutting, their Vice President, as our 1st Vice President.

With kindest regards and best wishes, I am, as ever, your friend,

FRED W. FOXWORTHY.

August 8th.

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117 E. Ashland St.,
Doylestown, Pa.,
July 29th, 1911.

Dr. A. W. Brayton,
Indianapolis, Ind.

Dear Doctor:—My brother Theodore sent me a copy of the Medical Journal containing your kind notice therein giving modest little "Queenie," the autobiography of an Italian Queen Bee. I thank you for your very pleasant notice of the

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work, and assure you I greatly enjoyed your whole article respecting the Honey Bee, particularly as she has figured in literature, so admirably set down by you.

I hope this finds you and your family well. I remember you with great pleasure. As for myself, I am well and happy, but have become so deaf that I must depend on the Acousticon instrument and even then have difficulty. But I see many who are worse off than am I. So, I say, there is always much for which to be thankful.

Sincerely yours,
T. CHALMERS POTTER.

Saranae Lake, N. Y.
August 20, 1911.

My Dear Dr. Brayton:

I wish you were here to enjoy this beautiful region with me for I know you would enjoy it. Lakes and mountains with a clear invigorating air and constant out-of-door life so that for the past two weeks or more I have been dividing the time between rest, fishing, golf and a certain amount of time spent in the Trudian laboratory and several visits to the Adirondacks Cottage Sanitarium.

There is a fine group of men here—all devoted with sustained interest to the study and treatment of tuberculosis. In the village proper Dr. Baldwin is the leader and a most charming gentleman he is—and just as keenly interested in the study of the disease after twenty years spent in the work as he ever was. He devotes a great deal of his time to the laboratory and to the reception hospital and only does consulting work in private practice. He talks to one about tuberculosis in a way to make you wonder at the vast information he possesses and yet simply as only a great teacher or clinician can talk—entirely absorbed in the subject yet so far as I can see absolutely free from the slightest taint of egotism or lack of tolerance for the methods of others. I am impressed with his broad knowledge of what is being done in all parts of the world in this work. Of the younger men who are working here I shall tell you when I see you. It seems that any man who comes here with a reasonable scientific hypothesis is given a chance to work it out.

Dr. Brown at the head of the Trudian Sanitarium has been very cordial and as you said "he knew our Dr. Potter" and was interested to know about him. He is doing a great work and the sanitarium is instructive as to how such an institution should be run. I am not devoting a great deal of time to study though I feel that in one sense I need it very badly but believe the rest and fishing have also their place in a vacation.

I trust that you are very well and spending as much time as possible in Brown County. Trusting to see you about Sept. 5th, and with best regards, I am, Yours very truly,

MacDonald.

August 15, 1911.

Dear Doctor Earp:—

This statement was prepared for the Journal by Dr. Van Reed, coroner, at my request.

W. W. V.

The tragic death of Dr. Louis P. Englemen, which occurred on the night of Aug. 5th, 1911, was a great shock to his many friends. The Doctor had not been feeling well for some days previous to his death.

On Monday, Aug. 7th, 1911, the lifeless body of the Doctor was found in the rear room of the office. The instantaneous water heater was burning and had no vent to carry off the fumes. The coroner's verdict was that of accidental death by asphyxiation. It is supposed that the Doctor was overcome by the intense heat and had fallen to the floor, death resulting from the inhalation of carbon monoxide fumes.

Dr. L. P. Englemen was born in Louisville, Ky., in 1871. He graduated from the Louisville Medical college, Louisville, Ky., in 1897 and shortly afterward located at Mechanicsburg, Ind., where he practiced for nine years, moving to Lafayette in 1908.

Since locating in Lafayette, Ind., he

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built up a large and lucrative practice and was recognized as a physician of ability.

Dr. Engleman was a Mason and a member of the order of Ben Hur.

The body was sent to Louisville, Ky., and interred at that place.

"BOUNCING DR. WILEY."

"What makes the Potted Ham so green?" said Files-on-Parade.
"It's feelin' fresher than it is," the Color Sergeant said,
"What makes the ranks so white, so white?" said Files-on-Parade.
"They're dreadin' what they've got to eat," the Color Sergeant said.
"For they're bouncin' Doctor Wiley, you can hear the Microbes cheer,
And the Germs is all a-singin', 'Wiley's goin' away from here,
And we're coming back far stronger than we've been for many a year,
For they're bouncin' Doctor Wiley in the mornin'."

"What makes the canned goods work so 'ard? "said Files-on-Parade.
"They're fixin' for their Jubilee," the Color Sergeant said.
"What's made that front-rank man fall down?" said Files-on-Parade.
"He's eat cold-storage sassidges," the Color Sergeant said.
"They are bouncin' Doctor Wiley, and those sassidges of old
Are swarmin' from their prisons where they've lingered in the cold.
And they've brought their ptmaines with 'em in a manner free and bold.
For they're bouncin' Doctor Wiley in the mornin'."

"'E uster work 'longside 'o me," said Files-on-Parade.
"'E helped me tackle many a germ!" the Color Sergeant said.
"'I've drunk 'is beer a score 'o times," said Files-on-Parade.
"And mighty steerile stuff it was!" the Color Sergeant said.
"They are bouncin' Doctor Wiley, they are giving him the larf;
They are cuttin' off 'is wages and 'is red official scarf,
And you and me must analyze ourselves our 'arf an' 'arf,
For they're bouncin' Doctor Wiley in the mornin'."

"For what do they be bouncin' him?" said Files-on-Parade.
"'E put the Microbes on the blink," the Color Sergeant said.
"An' did the Microbes 'urt the Blink?" said Files-on-Parade.
"They put the Blink out of a job," the Color Sergeant said.
"They are bouncin' Doctor Wiley and the germs are runnin' free,
And the Microbes and Bacilluses are shortlin' with glee,
For they'll get their starvin' 'ooks once more on folks like you an' me.
After bouncin' Doctor Wiley in the mornin'."

Dr. Wiley will attend the State Association meeting. He is a graduate of the old Indiana Medical College in which he taught chemistry. He also taught in Butler College, and the Purdue University. Dr. Wiley and the writer each had typhoid fever and were both under care of the great teacher and practitioner Dr. Thomas B. Harvey, who at one time got us together along with Dr. John Chambers in his old office, North and Pennsylvania streets, and reviewed the cases in every detail of a three months' tedious sickness and relapse each of us had suffered. The writer of this note spent a week with Dr. Wiley as a happy convalescent from the fever, as his guest at Purdue University. He taught physics—electricity was the day's work with pith balls, bits of silk, rubber combs and rulers, catskins, etc., as the illustrative material.

But Dr. Wiley got the first Siemens Dynamo for the university ever brought to the West. It was a duplicate of the one horse power dynamo at the Centennial Exposition, 1876, and was used to light the magic lantern. It now has the post of honor at Purdue. Dynamos and Dr. Wiley have been "going some" since those young manhood days. A. W. B.

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MISSISSIPPI VALLEY MEDICAL ASSOCIATION.

On October 26, 1875, the Tri-State Medical Society was organized at Vincennes, Ind., composed of physicians of Indiana, Kentucky and Illinois, which, while confined at first to these States, later permitted medical men from the neighboring commonwealths to join, which eventuated in the formation of the Mississippi Valley Medical Association. According to the Transactions of the Indiana State Medical Society, 1906, the first officers, at its organization at Vincennes, were: Dr. Joseph Thompson, Kentucky, president; Drs. W. A. Smith, Illinois, J. K. Letcher, Kentucky, and J. B. Armstrong, Indiana, vice-presidents; Dr. George M. Burton, Indiana, corresponding secretary; Dr. F. W. Beard, Indiana, recording secretary; Alfred Patton, Indiana, treasurer. Most of these have joined the silent majority. From such a modest beginning the Association has grown until it now comprises the majority of the leading men of the profession between the Alleghenies and the Rockies, a region an empire in extent and resources. In a recent issue we published the preliminary program. We shall recur to it again at some future time. Suffice it to say now that Dr. Robert H. Babcock, of Chicago, will open a meeting at Nashville, October 17 next, which for interest, importance and sociability will scarcely be second to the recent session of the American Medical Association.

COMPILIED FIGURES ON "POLIO."

State Officials Seek to Compel Physicians To Report Cases.

Officials of the State Board of Health have compiled figures relative to the cases of poliomyelitis within the state, and from the report blanks sent in by physicians only six cases have been reported from urban communities, while thirty-three have originated in the country. More than fifty cases of the disease, it is said, now are extant in Indiana, and the state health officials are conducting a vigorous campaign to compel physicians to send in reports. Twenty-three of the cases which have been reported officially were males and sixteen females. Direct contact with persons suffering from the disease is given as the cause of three others. The third case of poliomyelitis in Indianapolis was reported to the city and state boards of health from the family of Joseph T. Lawrie, 20 East Raymond street. An 8-months-old boy is suffering from the disease. Dr. A. W. Miller, who has charge of the case, said that the boy first was attacked by severe chills, and later his right lower limb was almost completely paralyzed.

TRAINMEN TO ENFORCE LAW.

Will Be Empowered to Prevent Drinking While in Illinois.

Chicago, June 24.—Beginning July 1, every railroad conductor on trains running in Illinois will assume the duties of Sheriffs or policemen. All railroads are preparing placards quoting the law just passed by the Illinois State Legislature making it unlawful to drink intoxicating liquors or to be intoxicated in or upon railroad passenger cars or about any railroad station.

The law says that there shall be no drinking in smoking cars, parlor cars, day coaches, interurban cars, and cabooses used for the transportation of passengers. It does not mention buffet cars. Railroad conductors will be called upon to act for the State in arresting violators. Furthermore, they will become liable to a fine if they fail to do so.

REGISTRATION AREA VITAL STATISTICS.

Preliminary Statements Given Out By The Census Bureau.

Washington, D. C. September 8, 1911.—Preliminary statements regarding the vital statistics of the United States have been submitted to Census Director Dorand by Dr. Cressy L. Wilbur, chief statistician for vital statistics in the Bureau of the Census.

One of these is a comparative summary of the number of deaths from all causes per 1,000 population in the death registration states for 1900 and 1910. In Cal-

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ifornia the rate per 1,000 population was 13.5 in 1910; in Colorado, 13.8 in 1910; in Connecticut, 15.6 in 1910 and 18.0 in 1900; in Indiana, 13.5 in 1910 and 14.2 in 1900; in Maine, 17.1 in both 1910 and 1900; in Maryland, 16.0 in 1910; in Massachusetts, 16.1 in 1910 and 18.3 in 1900; in Michigan, 14.1 in 1910 and 14.0 in 1900; in Minnesota, 10.9 in 1910; in Montana, 10.6 in 1910; in New Hampshire, 17.3 in 1910 and 18.5 in 1900; in New Jersey, 15.5 in 1910 and 17.8 in 1900; in New York, 16.1 in 1910 and 18.2 in 1900; in Ohio, 13.7 in 1910; in Pennsylvania, 15.6 in 1910; in Rhode Island, 17.1 in 1910 and 20.5 in 1900; in Utah, 10.8 in 1910; in Vermont, 16.0 in 1910 and 16.6 in 1900; in Washington, 10.0 in 1910; and in Wisconsin 12.0 in 1910. Stillbirths are excluded from the basic figures.

In 1900, California, Colorado, Maryland, Minnesota, Montana, Ohio, Pennsylvania, Utah, Washington and Wisconsin were not included in the death registration area from which transcripts of all deaths are returned to the Census Bureau for statistical purposes, so that comparisons for these states cannot be made.

Another tabulation shows that there were 36,309 deaths from all forms of tuberculosis reported during the calendar year 1910 from the death registration area.

The estimated population of Continental United States on July 1, 1910, was 92,309,348, while that contained in the death registration area was 53,843,896, or 58.3 per cent of the grant total. On this basis there were 160.3 deaths from all forms of tuberculosis per 100,000 population in 1910.

In the death registration area in 1909 the number of deaths, by sex, from tuberculosis of the lungs was 39,456 males, 30,584 females; tuberculosis of the larynx, 529 males, 275 females; tuberculosis meningitis, 2,448 males, 2,127 females; abdominal tuberculosis, 1,399 males, 1,642 females; Pott's disease, 435 males, 305 females; tuberculosis abscess, 42 males, 30 females; white swelling, 233 males, 146 females; tuberculosis of other organs, 516 males, 369 females; general tuberculosis, 611 males, 573 females; scrofula, 68 males, 47 females.

From diseases of the respiratory system the number of deaths, by sex, reported from the death registration area in 1909 were: laryngitis, 188 males, 146 females; other diseases of the larynx, 257 males, 179 females; diseases of thyroid body, 40 males, 154 females; acute bronchitis, 2,284 males, 2,904 females; bronchopneumonia, 10,757 males, 10,269 females; pneumonia, lobar and unqualified, 27,564 males, 21,443 females; pleurisy, 1,215 males, 867 females; congestion of lungs, 1,299 males, 1,251 females; gangrene of lungs, 159 males, 62 females; asthma and emphysema, 859 males, 697 females; hemorrhage of lungs, 375 males, 226 females; other diseases of the respiratory system, 470 males, 264 females.

In the death registration area, during the calendar year 1910, the deaths from typhoid fever numbered 12,673; malaria, 1,167; measles, 6,598; scarlet fever, 6,255; whooping cough, 6,146; diphtheria and croup, 11,521; influenza, 7,774; purulent infection and septichemia, 1,877; tuberculosis of the lungs, including "acute miliary tuberculosis," 75,211; simple meningitis, 5,347; cerebrospinal meningitis, 2,052; cerebrospinal fever, 220; pneumonia, lobar and unqualified, 54,187; diarrhea and enteritis, under 2 years of age, 54,-age and over, 8,914.

Another comparative table shows that in the death registrations for the census year 1879-1880, the death rate per 1,000 of population was 19.8; for the census year 1889-1890 the rate was 19.6; for the calendar year 1900, the rate was 17.6; for the calendar year 1904, the rate was 14.4; and for the calendar year 1910 the rate was 15.0. In 1879-1880 the population of the registration area formed 17.0 per cent of the grant total for continent United States; in 1889-1890, 31.4 per cent; in 1900, 40.5 per cent; in 1909, 56.1 per cent; and in 1910, 58.3 per cent.

In the state of Washington the number of deaths from all causes, exclusive of stillbirths, per 1,000 of population, in 1908 was 9.3; in 1909, 9.8. In Seattle the

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number in 1900 was 11.1; in 1901, 9.7; in 1902, 10.2; in 1903, 9.5; in 1904, 9.3; in 1905, 8.1; in 1906, 9.5; in 1907, 10.8; in 1908, 9.3; and in 1909, 10.0. In Spokane, the number in 1901 was 10.9; in 1902, 11.2; in 1903, 13.3; in 1904, 11.1; in 1905, 10.2; in 1906, 11.2; in 1907, 13.3; in 1908, 13.4; and in 1909, 12.6. Spokane was not included in the registration area in 1900. In Portland, Oregon, the number in 1900 was 10.2; in 1901, 11.3; in 1902, 10.0; in 1903, 10.2; in 1904, 10.3; in 1905, 9.7; in 1906, 9.4; in 1907, 11.0; in 1908, 9.9; and in 1909, 9.8.

FOUNDER'S DAY, FLETCHER SANITARIUM.

Founder's Day is kept every year on Aug. 18, in memory of Dr. Fletcher who was the founder of the institution. The exercises this year were held on the terrace and the grounds were beautifully decorated with Japanese lanterns. It was also the occasion of the graduation of Nurses who had completed a three years course of instruction.

Miss Mary T. Wilson of the Board of Directors made the opening address. Dr. Chas. F. Neu made the address to the graduating class. Dr. Urbana Spink presented the diplomas and class pin.

The names of graduates were as follows: Miss Ida Virginia Wroten, Anderson, Ind; Miss Josephine M. Dollen, Versailles, Ind.; Miss Clara D. Ford, Owensboro, Ky.; and Miss Enola Marie Snodgrass, Gosport, Ind.

The exercises were followed by refreshments and dancing in the gymnasium for the Nurses and their friends.

NEWS ITEMS.

Dr. and Mrs. Louis Burkhardt summered in Leland, Mich.

Dr. and Mrs. Kenneth I. Jeffries summered at Crooked Lake.

Dr. and Mrs. Theodore Potter took a pleasure trip to Canada.

Dr. and Mrs. M. J. Spencer spent a fortnight at Atlantic City.

Dr. Thomas B. Noble has returned from a fishing trip in Canadian waters.

Dr. and Mrs. Joseph Rilus Eastman have returned from Ocean Grove, N. J.

Dr. and Mrs. Frederick C. Heath have returned from a visit to Gardiner, Maine.

Dr. Chas. F. Haskell attended the American Pharmaceutical Convention in Boston.

Dr. and Mrs. Clark E. Day have returned from Detroit, Mich., and Cedar Point, Ohio.

Dr. and Mrs. E. D. Clark have returned from a month's pleasusure trip to Nantucket Island, Mass.

Dr. A. C. Kimberlin sustained a broken arm as the result of an imperfect cranking of his automobile.

Dr. J. H. Talbott, of the Insurance Department of the Big Four R. R., spent August fishing at Annandole, Minn.

Dr. J. O. Stillson has removed his office from 445 North Pennsylvania street to 516 Indiana Pythian Bldg., corner of Mass. Ave. and Pennsylvania St.

Dr. Arthur E. Guedel announces that he is prepared to give nitrous oxide-oxygen anesthesia for major and minor surgery at the service of the patient upon recommendation of the surgeon.

George Washington Fertich, M. D., Medical College of Indiana, Indianapolis, 1886; for twenty years local surgeon for the Panhandle System; died at his home in Dunkirk, Ind., August 3, from cerebral hemorrhage, aged 69.

Mr. A. E. Butcher has the honor of announcing the marriage of his daughter Ethelyn Marie to Dr. Fred McKemy Ruby on Thursday, Sept. 7, 1911, at Rich-

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mond, Ind. Dr. and Mrs. Ruby will be at home at 806 W. Division St., Union City, Ind.

Dr. A. C. Hirschfield, professor of physiology in Oklahoma University, visited Indianapolis, Sept. 3. He is a graduate of the Indiana University School of Medicine and he and Dr. Bohn were the first internes at the Methodist Hospital, at Indianapolis.

Dr. Wm. Flynn, 61 years old, died at Marion, Ind., Sept. 1. He was an adopted child of Dr. Wm. Lomax and at one time a teacher in the Indiana Medical College. The will found in the safe of Dr. Flynn gives all his estate, supposed to be worth sixty thousand dollars, to Indiana Medical College.

Dr. Will Kemper left July 24 for his new home near Lancaster, O. He made the trip alone in his automobile. Dr. Kemper has built a handsome new house on his farm and will get it in readiness for occupancy and will then be joined by Mrs. Kemper. In the loss of Dr. Kemper, Muncie loses one of its best physicians and a splendid citizen. On account of his health Dr. Kemper found it advisable to leave his practice and his friends here hope that his change of residence will be of benefit to him and his excellent family.

Dr. Carl Beck, of New York, died at his country home at Pelham Heights, Westchester county, N. Y., June 8, 1911, of pneumonia. He was born at Neckargernuend, Germany, April 4, 1856, and received his medical degree at Jena in 1879. He came to New York in 1882, and soon gained prominence as a surgeon, also as an authority in x-ray work. He was professor of surgery and attending surgeon at the New York Post-Graduate Medical School and Hospital and afterward consulting surgeon to the German Polyklinik of New York. Dr. Beck was inventor of numerous surgical devices and the author of several works in English and German, including Rontgen Ray Diagnosis and Therapy, Surgical Diseases of the Chest and a Textbook on Fractures. His son, Dr. Carl Eric Beck is attending surgeon to St. Mark's Hospital, New York.

John E. Lockeridge, M. D., Medical College of Virginia, Richmond, 1863, of Indianapolis, died recently at the home of his niece in Nevada, Iowa, and was buried in Indianapolis, August 15. Dr. Lockeridge has been a resident of Indianapolis for more than forty years during which time he possessed the confidence of those who knew him. For a number of years he was attending physician at the State Institution for the deaf and dumb and for one term was a member of the City Board of Health. He was a contributor to quite a number of medical journals and a fluent reader of Latin and Greek. This journal has frequently published articles written by him. He has written some poetry which was considered of sufficient merit to receive attention of the public press. For ten years past he has had an office at the southeast corner of Market and Illinois streets but he was not very active in the practice of medicine on account of organic heart disease. In church affiliation he was an ardent Episcopalian and in politics a democrat.

The elderly matron with the bundles who was journeying to a point in Wisconsin and occupied a seat near the middle of the car, had fallen asleep. On the seat in front of her sat a little boy. The brakeman opened the door of the car and called out the name of the station the train was approaching. The elderly woman roused herself with a jerk.

"Where are we, Bobby?" she cried.

"I don't know, grandma," answered the little boy.

"Didn't the brakeman say something just now?"

"No. He just stuck his head inside the door and sneezed."

"Help me with these things Bobby," she exclaimed. "This is Oshkosh. It's where we get off." —Med. Standard.

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BOOK AND JOURNAL REVIEWS.

MANUAL OF DISEASES OF THE EAR, NOSE AND THROAT. By John Johnson Kyle, B. S., M. D., Professor of Otology, Rhinology and Laryngology, Indiana University School of Medicine; Otologist, Laryngologist and Rhinologist to City Hospital, St. Vincent's Hospital and City Dispensary, Indianapolis, etc. Third edition, revised and enlarged, with 176 illustrations. Philadelphia: P. Blakiston's Son & Co., 1911. $3.00 net.

A few changes have been made in the text of the earlier edition of Dr. Kyle's book! some important additions enhance the value of this book, as has been noticed by many reviewers. The present form of the book contains 642 pages and is bound in flexible leather. The work of the publishers, as in all of this series, is all that can be desired. Much attention has been paid to differential diagnosis and treatment of diseases of the labyrinth. The differentiation of suppuration of the labyrinth from middle ear suppuration and cerebellar abscess is a subject of great interest, and is made very distinct to the reader and operator. Until within the last two or three years labyrinthian diseases had been obscure and not well differentiated. The section on this subject presents all the new researches made in this group. The chapter relating to the faucial tonsils has been completely revised. The technique of tonsilectome is fully set forth with illustrations showing the different steps necessary for a complete extirpation of the tonsil with its capsule.

A number of the more modern instruments are illustrated, particularly the Barany noise apparatus. This is an instrument used as an aid for the detection of simulated deafness and deafness resulting from labyrinthine suppuration.

The chapter on Anatomy has been fully revised and much essential information added. The chapter on Therapy contains much of value to the student and general practitioner, and has been rearranged and new formulae added. Some forty to fifty pages have been added to the book, representing the entire additions to the science since the preceding edition was written.

The author in the introduction has continued to advocate simplicity in operations, and has urged against the expensive habit of buying many instruments which have little virtue except in the view of the manufacturer and the apostles of newness.

PROGRESSIVE MEDICINE. A Quarterly Digest of Advances, Discoveries and Improvements. Edited by Hobart Amory Hare, M. D. Volume III. September, 1911. Lea & Febiger, Philadelphia and New York. 1911.

The September number of Progressive Medicine gives a splendid review of the diseases incident to viscera of the chest, the blood vessels, the skin, syphilis and also such important matters as we find relative to the nervous system and obstetrics. Davis discusses at length almost everything concerning pregnancy placing some emphasis upon the puerperal period and obstetric surgery. The topics poliomyelitis and pellagra are taken up with many other good things in the chapter on the nervous system, by Spiller. It closes with miscellaneous nervous diseases. Gottheil devotes considerable space to arsenobenzol. The same writer mentions the fact that Southerland calls attention to harm done by the administration of arsenic in eczemas of all the acuter varieties. Water must be avoided for cleansing purposes and diluted alcohol or warm olive oil substituted for it. Milk is added to the list of cleansing agents because it is alkaline, bland and effective. Sweating keeps up irritation of the skin and retards the cure, it may be combated by dusting

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powders. He greatly favors the use of liquor alumini acetici of the German Pharmacoepeia, made according to the new formula without lead.

Bunch suggests a cream that Gottheil greatly favors not only as regards its own special composition, but as a base with which may be incorporated any other drug, salicylic acid, boric acid, or any of the tars, that may be indicated. It is prepared thus: Zinc oxide, 40 gm.; pure glycerin, 60 c.c.; rose water, 150 c.c.; mix and shake thoroughly; let the mixture stand three days; decant the supernatant fluid, and use the remaining cream. The three days' wait would be a novel part of the recipe that would hardly find favor with us; and I would suggest that the rose water be diminished to 40 or even 20 c.c. in the above, and the mixture compounded in a mortar instead of by shaking. In fact, by varying the above proportions, a cream of any consistency can be made, but care must be taken of two points. The trituration must be thorough, so that no particles of zinc or other solid ingredients remain of sufficient size to prove irritating, and a certain amount of water must be added to the glycerin, which in its pure state is liable to be very irritating.

Ewart speaks of the forecast as to the next move in the campaign relative to the sanatorium, the dispensary, the tuberculin dispensary and the tuberculin treatment. He learnedly discusses the various diseases of the thorax and its viscera, including the heart, lungs and blood vessels. What is said about the heart and its affections will be read with interest. Much important information can be obtained concerning arterial blood pressure and its measurement. The various methods of the measurement of blood pressure are given in detail. Several recent cases of phlebitis which have been under my observations in Indianapolis interest me in the treatment advocated by Fischer and quoted by Ewart. It is simple, quick and also safe, provided the thrombosis does not extend upward beyond the reach of the pressure of the bandage. That firm pressure is the secret of the rapid absorption of the clot; and this constitutes a great advance over the old treatment by rest. It would not be difficult at all to call attention to a great many topics which are especially meritorious, but is far better to suggest that the reader review the various subjects in detail himself.

S. E. E.

JOINT TUBERCULOSIS. By Leonard E. Ely, M. D., New York. William Wood & Company, 1911. Price, $2.50.

This monograph of over two hundred pages is divided into two sections; the first deals with joint tuberculosis in general, the second with tuberculosis of special joints. On the whole the work is an excellent guide for both students and practitioner, and is much superior to the sections on this subject found in the general run of system and text-books on surgery. Dr. Ely's work gives the impression that the author has given time and painstaking labor on a subject in which he is especially interested. It is a record of personal observations and deductions, and while all of his ideas may not stand the test of time, they will have formed, nevertheless, a step forward in the understanding of tuberculosis of joints.

Several new facts in regard to the pathology of the disease seem to be well demonstrated. The first which seems to be of special importance is the following: "Where red marrow is found in the bone, the bone is subject to tuberculosis infection and where it is not found, there the bone is immune, or almost immune, to a purely tuberculosis infection." If this be true, it is a very important fact from a practical standpoint, as it is possible to make a bone lose its red marrow by destroying the epiphyseal end which will convert the structure into cancellous bone, containing yellow marrow, which is not subject to tuberculosis.

Again, he has found that the primary synovial type of tuberculosis is much more common than we have generally suspected. He further states:

"We hold that any operation which deprives the synovial membranes of func-

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tion causes them to lose their distinctive structure and to change into fibrous connective tissue, and hence cures the tuberculous disease in them."

Both of these pathological findings bear a marked influence upon the treatment and it is also possible to use less radical operative measures.

The chapter on general treatment of joint tuberculosis may be summed up as follows:

The best policy is hygienic treatment with immobilizing of joints in children and resection of that part of the joint containing red marrow in adults. While treatment by Tuberculine and Bier hyperemia is mentioned, enough stress does not seem to be laid upon these valuable methods of conservative treatment, especially the former, which has been found by many other workers to cure joint tuberculosis, even in adults without extensive operative measures. There is an interesting appendix on pathological processes in tuberculosis by Dr. G. B. Webb of Colorado Springs.

J. V. R.

PRIMER OF HYGIENE. By John W. Ritchie, College of William and Mary, Va.; and J. S. Caldwell, Peabody College for Teachers, Tenessee; 8vo., cloth, pp. 184, illustrated, price, 40 cents. World Book Co., Publishers, Yonkers-on-Hudson, N. Y., 1910.

This little work is written in language so plain that a ten-year-old child can understand it, and its purpose is to teach the lower grade pupil in our schools what health-personal hygiene. It tells the elementary facts that every one should know to keep his body in health, and although every chapter is most excellent, we can especially commend those on the Care of the Teeth, on Adenoids and Enlarged Tonsils. A practical book for practical purposes.

PRINCIPLES OF PUBLIC HEALTH. By Thos. D. Tuttle, B. S., M. D., Secretary of the Health Board of Montana is another simple and excellent book on hygiene setting forth the principles for conserving health for the individual and the community. It is published by the World Book Company. Pages, 106; illustrated. Price, 40 cents.

MANUAL OF EMERGENCY SURGERY. By John W. Sluss, A. M., M. D. Second edition, revised. With 605 illustrations. 12mo., 748 pages. Full limp leather, gilt edges, round corners. Philadelphia: P. Blakiston's Son and Company. Price, $3.50 net.

One's emergency surgery depends on locality and chance as well as on reputation. The country physician sometimes has to assume responsibility for a surgical emergency that may be infrequent even in a city hospital. This is probably the reason for including in this manual chapters on spinal anesthesia, craniectomy, intestinal surgery, cystotomy, radical cure of hernia, etc., along with much matter sometimes termed minor surgery.

There is a legitimate field for a brief work like this book in every department of medicine provided only that it be definite, practical and accurate. Dr. Sluss has in the main been very happy in what he has omitted as well as in what he has included in this second edition of a useful work. The illustrations, taken largely from French authors, are numerous and helpful.

The above sympathetic notice of Dr. Sluss's book from the Pennsylvania State Medical Journal of June, expresses the feeling of appreciation that all the reviewers share in common. The Surgery of Sluss; the Nose and Throat work of Kyle, the treatise on the Ear by Barnhill and Wales are all standard works and reflect credit on the authors and on Indiana, also as a teaching medical center.

THE EVOLUTION OF URINE ANALYSIS. An Historical Sketch of the Clinical Examination of Urine. Lecture Memoranda, American Medical Association, Los Angeles, 1911. Burroughs Wellcome & Company. London, (Eng.), Montreal, Sydney, Cape Town, Milan,

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Shanghai, Buenos Aires, and 35, 37 & 39 West Thirty-third Street. New York City.

This little book, presented to the members of the American Medical Association at Los Angeles, contains copies of many old and famous prints of various urologists and their methods of work. The text deals with the history and evolution of the use of urine examination in diagnosis from the earliest antiquity to the present time. It seems that the ancients had a much more elaborate scheme of diagnosis from the color and appearance of urine alone than we have at present with our elaborate chemical and physical tests. A few of these appearances were apparently of some practical value.

The first work having a real scientific flavor was written in 1540, in which elaborate charts and schemes were given for diagnosis based chiefly upon the color and sediment. About the sixteenth century the examination of urine was used largely by quacks and charlatans. The beginning of the real value of urine examination begun with the discovery of urea by Boerhaave in 1738.

J. V. R.

DR. KEMPER'S MEDICAL HISTORY OF INDIANA.

Dr. Kemper's book is now on sale and has been since the first of August. Many reviews have appeared in the State press. The book is bound to have a large reading among historians and general readers, as well as among the physicians to whom it is dedicated. It should be in the hands of every member of the State Medical Association. The writer of this note has met a number of newspaper people, book reviewers who have natural instinct for finding a good thing, and all of them were interested in Dr. Kemper's book.

Dr. Kemper was half a century preparing to write this book. He had a large acquaintance, he was a wide reader, an active member of the State Medical Society, and his papers on medical subjects always commanded attention, being instructive in matter as well as being written in a natural and simple style. He considered large subjects; he handled them well; he was accurate in detail; he did not trust to memory; he had had a large experience; he had been the necrologist of the Society; he was, unconsciously, in every way prepared for the writing of this book when he commenced it three or four years ago. Indiana now has the best history of its medical profession yet published by any State of the Union. Doctors have been in this State over one hundred years. Dr. Kemper has been a physician himself for fifty years. He relates both the old and the new. It is to be hoped that he may live long and see successive editions of this book sold and read not only in his own State, but in adjacent States.

LANDMARKS AND SURFACE MARKINGS OF THE HUMAN BODY. By Dr. Louis Bathe Rawling, Assistant Surgeon and Demonstrator of Practical and Operative Surgery, St. Bartholomew's Hospital; late Assistant-Surgeon to the German Hospital, Balston; late Hunterian Professor, Royal College of Surgeons, England. Fourth edition, revised. 8 vo. cloth, 32 full-page illustrations, and 91 pages of text. Price, $2.00. Sent on receipt of price to Paul B. Hoeber, 69 E. 59th St., New York. 1911.

Succint chapters are given to the head and neck, upper extremities, thorax, abdomen, and lower extremities. There is an appendix giving the weight of various organs, length and relation of certain passages and tubes, and the ossification and epiphyses of the bones of the extremities. The illustrations are all that can be desired. The abstracts from the review made of this work in the American Journal universally commend it. Its admirable illustrations, its descriptive text, present clearly and concisely the surface anatomy of the body, and the surface relation of deep anatomic structures. It is a manual of standard value for students, teachers and practitioners of medicine. By the use of this book any practitioner can mark out on his own or another's body the lines and points necessary to know in considering

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fractures, dislocations and anatomical interior relationships. When a student has done this two or three times following this book on the body of a classmate, much useful knowledge will be impressed upon his mind in a manner never to be forgotten. We commend this book to medical men and students.

DR. MITCHELL'S LITTLE SERMON.

More of the Physician's Knowledge Than The Novelist's Art in His Latest Book.

There is rather more of the physician's knowledge than the novelist's art in Dr. S. Weir Mitchell's story, "John Sherwood, Ironmaster," which amounts to a little sermon on physical and spiritual wellbeing plus several interesting pathological studies. John Sherwood himself comes dangerously near to being merely the subject of a successful demonstration —his life an object lesson. Five chapters —the best of the book—bring him to the point where the cure begins.

A distinctly Philadelphian atmosphere pervades these early pages; little is said of places, but the tone of this particular locality is discernible in the very color of the orphan boy's life, in the characters of Cousin Euphemia and the two bleak uncles and in the industrious sobriety of the young inventor and mill-owner. The moulding of the imaginative child through the discipline of a laborious youth into an unimpressionable man, narrowly concentrated upon the business of the iron manufacturer and alive to inspiration only on the side of mechanical invention, is indicated with a very effective simplicity and plainness.

With the physical breakdown, inevitable consequence of years of over-intent application, comes the transplanting of the patient to the Maine woods and wholesomely primitive conditions, where the physician's morality begins. The curative properties of an open-air existence and an interest in one's fellow-men become speedily apparent. Disused powers of imagination and sympathy come into play again. The ironmaster develops a poet's vocabulary and observant love of nature, human as well as inanimate, along with a habit of speculation on abstract themes. In short, his thought and style of expression come to correspond closely with those of the accomplished connoisseur of human types and manners whose pen is employed in the portrayal.

A plot is set in operation involving a tragic case of incurable dementia, (its developments set forth explicitly, but without much professional comment,) and ending in one of those discreet romances of mutual respect and self-restraint which no other contemporary writer affords. A courtship of stately reticences is a welcome relief amid an overabundance of passionate display. The very novelty prompts the query whether the method of lovemaking no longer exists anywhere outside of Philadelphia.

The weakness of the novel lies in the inventions of the plot, whose coincidences overtax credulity; its strength lies in the just record of much human experience by an observer of exceptional talent and opportunity. No event of the story compares in interest with the observations upon the inconsistent and incalculable Euphemia and upon the hero's attitude toward this elderly cousin at various stages of his career—the child's lack of confidence, the boy's insubordination, and the man's amused, indulgent kindness.

Anciently barbers were surgeons, especially in cases of bleeding. To assist this operation the patient used to grasp a staff or pole, which was always kept near the barber-surgeon. To this staff was tied a rope, which was used in bandaging the patient's arm. When not in use the pole was hung outside, as a sign of the work performed inside. Later a stick painted to represent the pole was left in the doorway. At first surgeons' poles were painted with red and white stripes, with a brass knob or basin at the top, while mere barbers were required to have them white and blue. This statute was still in force in England in 1297.

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PUBLISHER'S DEPARTMENT.

All correspondence relating to the Business Affairs of this Journal should be Addressed to H. M. Patterson, Business Manager, 77 N. New Jersey St., Indianapolis.

FOR SALE.

Location within twenty miles from Indianapolis. Good country home, good roads, good schools and rich community. $4,000 practice. Leaving on account of desire to locate in a college town. Address Box 4, Indianapolis Medical Journal.

FOR SALE.

Seven-room house and lot in town of about 300; good well, barn and out buildings. Located on B. & O. S. W. R. R. All new buildings. Several fruit trees. Good location for Doctor and drug store. No opposition. Territory 21x22 miles. Will sell reasonable and introduce purchaser. Address G. L. G., Huron, Ind. Box No. 38.

STERILIZED SOLUTIONS FOR HYPODERMIC USE.

In view of the pronounced demand for sterile "ready-to-use" solutions of definite dosage, to be administered hypodermically, Parke, Davis & Co. some time ago decided to place a number of such solutions at the disposal of the profession in a form that would make their use both convenient and economical. "Sterilized Solutions in Glaseptic Ampoules" is the term used to designate them, and the company announces about a dozen preparations which it is prepared to supply.

The sealed glass ampoule removes the liability of contamination and deterioration, and eliminates the inconvenience attaching to the preparation of a solution whenever an emergency calls for its use. Moreover, it insures medicaments of established purity and strength. Each package contains a small file by means of which the neck of the ampoule is nicked, so that it may be readily broken off, thus opening the container. An ordinary hypodermic syringe is used. To withdraw the liquid, the needle is inserted to a point about midway of the sloping shoulder while the ampoule is held in a vertical position; by this means the solution is removable, we are told, to the "last drop."

Our readers are advised to consult the display announcement of these sterilized solutions appearing in the advertising pages of this issue of the Indianapolis Medical Journal which gives a complete list of the preparations as well as some important suggestions for their use.

"Just after you sent me a sample of Tongaline Liquid, I was called to attend a typical case of rheumatic fever, both ankles and knees being affected, accompanied with much pain and high fever.

I prescribed Tongaline to the exclusion of all other rheumatic agents, supposing that a treatment of several weeks would be required. On the second day after my visit, the patient's mother telephoned me that her daughter was free from pain and was resting comfortably.

About ten days afterwards I called again to ascertain how the patient was progressing and was greatly surprised to find that she was able to attend to her household duties, a marked improvement having occurred from the time she began taking the Tongaline, her appetite had returned and a complete recovery was only a matter of a short time."

A YOUNG GRAFTER.

Stranger—"Boy, will you direct me to the nearest bank?"

Street Gamin.—"I will for a shilling."

Stranger.—"A shilling Isn't that too much?"

Street Gamin.—"Bank Directors always get big pay, mister."

—Tit-Bits.

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PROMPT RELIEF IN SCIATIC PAIN.

In reporting his experience in the treatment of sciatica, Fred E. Davis, M. D., writes as follows in Annals of Gynecology: "I have been giving antikamnia & codeine tablets a thorough trial in the treatment of sciatica and I must say that my success has been phenomenal indeed. I have also induced two other physicians to give them a trial and their success equals or surpasses my own. I meet with many cases of sciatica and before adopting antikamnia & codeine tablets I used a great deal of opium and morphine to relieve the pain. Since then, I have not given either. One of my patients had been confined to bed for three weeks during her last attack of sciatica. I prescribed one antikamnia & codeine tablet every four hours and in forty-eight hours she was up and about and has not felt the pain since."

WHEN THE NERVES ARE IN A RIOT.

When the nerves are in a riot and the whiskey-laden patient sees green elephants turning hand-springs on his bedposts—then is there clear indication for PASSIFLORA INCARNATA (Daniel's Concentrated Tincture.) It will soothe the inflamed brain, quiet the quivering nerves and procure for the patient a deep, restoring sleep. PASSIFLORA INCARNATA (Daniel's Concentrated Tincture) is more potent than chloral and the bromides, and has none of their evil effects. A sample bottle sufficient for trial will be sent to any reputable physician upon request by Laboratory of John B. Daniel, Atlanta, Georgia.

EXTERNAL EYE DISEASES.

The most frequent forms of diseases of the eye are those located in the mucous membrane of the eye lids, (conjunctiva). When left alone they are not only a source of annoyance and suffering but often endanger the sight. The frequency of these external affections of the eye has made their treatment one of the richest mines for quacks from the oldest times. All general practitioners of medicine are frequently called upon to treat these diseases, which they can do successfully with perfect safety and not be under the necessity of sending their patients to the Oculist. It will be readily recognized from the formula of Palpebrine that it is composed of ingredients of no untried remedies but of such as are entirely reliable in the treatment of all external eye diseases. No detrimental effects can come from its use ad liberatum. Palpebrine is superior in its action to the remedies now in use. It contains all the constituents of Aqua Conradi, which is recommended by the renowned professor of the Vienna University, Ferdinand von Arlt (see Clinical Studies on Diseases of the Eye, by F. Ritter von Arlt, translated by L. Ware, page 23.)

The Dios Chemical Co. of St. Louis, will mail free sample with formula and literature on application.

THERAPEUTIC ACTIVITY PLUS PALATABILITY.

The popularity of a remedial agent that is therapeutically active and palatable, is assured, for beyond these qualities there is nothing to be sought. These are the features of Cordial of the Extract of Cod Liver Oil Compound (Hagee) that make it such a favorite with physicians.

As a reconstructive and tissue nutrient, it stands the most rigid clinical tests and the prescriber may feel sure that definite results will follow its administration. One of its fields of usefulness is in the protracted convalescence consequent upon a severe infection such as typhoid fever. Cord. Ext. Ol. Morrhuae Comp. (Hagee) stimulates the reconstructive functions and aids materially in hastening the return to health.

"Paraldehyde" possess many of the good without the evil qualities of chloral. Used in Insomnia resulting from various causes. The objectionable taste of the chemical, is, to a great extent, disguised in Robinson's Elixir Paraldehyd (see page 4-b this issue) which is an elegant preparation.

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WHY HE IS LONELY.

Thousands of people, having read of the vast fortunes made by those who write the so-called popular songs, have tried to accumulate riches and fame by writing lyrics and composing music. The mail bags of Jerome H. Remick & Co., probably the largest music publishing house in the world, are flooded with manuscripts by ambitious song writers. All are carefully looked over, but the percentage of those accepted is decidedly small; yet once in a while they receive one that amply repays them for all their trouble. Thus the new song, "Maybe That Is Why I'm Lonely, came into their hands, and it has proven such a success that the writers, Messrs. Goodwin and Meyer, have suddenly become renowned. A little love story with a strong heart interest is told by a lad in the song, who cannot understand why he is lonely away from the sweetheart, who, even while she is with him, gives him very little encouragement. He tries to account for it in the simple chorus which we quote. The music is especially appealing, and both lyric and melody combined are what is termed by the publishers a "double" inspiration song.

Chorus.

Maybe that is why I'm lonely,
Maybe that is why I'm sad.
Tho' you keep trying to have me sighing,
You can drive the blues away,
With any loving word you say, dear.
Come on, honey, cuddle closer,
Act like other sweethearts do.
If I only knew, dear, you were lonely too, dear,
I wouldn't feel so blue.

A TRUE HEPATIC STIMULANT.

Chionia is a preparation of Chionanthus Virginica and possess only the best therapeutic properties of that drug. It has been honored with a great number of testimonials from physicians of all schools, and the consensus of opinion is that it is a most trustworthy hepatic stimulant, when employed persistently in properly selected cases. Physiologically it may be described as a gradual vasomotor stimulant to the bile ducts, and many authorities contend that its use will improve portal circulation and strengthen the lymphatics. Dr. Geo. Covert has aptly referred to it as a "bile persuader," and indeed this describes its action in a nutshell.

TUBERCULOUS TAINTS.

Cotton seed oil has proven a very valuable tissue nutrient in patients with a "tuberculous taint." When it is remembered that cotton seed oil possesses pronounced nourishing properties, probably much more so than any agent now employed for the purpose, its power to add strength to weak tissues and overcome a tuberculous tendency will be appreciated. The best mode of use of cotton seed oil is its emulsion, known as NUTROMUL (Brown's Cotton Seed Oil Emulsion).

NUTROMUL is a pleasant product, containing a high percentage of the oil, which is fortified by the additions of the hypophosphites of lime, soda and manganese.

If you have not received a sample, drop a request to the Nottoc Laboratory, Atlanta, Ga.

THE MORAL.

"The persistency with which children see in a fable some other moral than the one which it is intended that they shall see is often distressing," remarks a Philadelphia instructor of the young. "I had recited to one little boy the story of the wolf and the lamb, and had followed it up with the remark:

"And now you see, Tommy, that the lamb would not have been eaten by the wolf if he had been good and sensible.'

"'Yes, I understand,' said Tommy. 'If the lamb had been good and sensible, we should have had him to eat!"

—Lippincott's.

DONT'S.

"Doctors should let the well enough alone." —Judge.

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THRIFTY.

Doctor—You'll be all right in a day or so. It's nothing but a slight cold.

Canny Patient—I was kind o' hopin' it was malaria, Doc. I've got a lot o' quinine an' I hate to see it go to waste.

—Judge.

TROLL OF DAWN.

Lo! a woodland roundelay
Chants the stately march of day;
Fairer flags than night winds furl
Are the flags of dawn, unrolled,
Waving westward fold on fold,
Ivory and rose and pearl.

Flash of fin and splash of spray
Dart and dance, athwart the bay,
Flecking all the heaving sea,
Not with noon's barbaric gold,
But with hues more strange and cold,
Rose and pearly and ivory.

—Raymond Crompton Rhodes in Woman at Home.

A TEMPERANCE ADMONITION.

Singing Teacher—Now, children, give us "Little Drops of Water" and put some spirit in it.

Principal (whispering)—Careful, sir. This is a temperance school. Say "Put some ginger in it."

SHE KNEW WHAT SHE WOULD DO.

The new minister was noted as an indefatigable talker, and when Mrs. Schuyler, who was very busy, saw him coming she decided not to receive him. She instructed her daughter, aged four, accordingly.

"Mamma says she's not in," said the little one when she opened the door in response to a ring.

"You go tell your Mamma," said the minister impressively, "that I'd like to know what she'll do if St. Peter sends her that kind of a message when she knocks at the gate of Heaven."

"She says," said the child when she returned, "that she'll do what you'll do, only she won't make so much fuss."

—Lippincott's.

HEROIC TREATMENT.

The physician turned to the office patient in the canvas coat and leggins.

"You must follow my directions implicitly," he said, handing him a small vial of liquid. "You are to take three drops in water every four hours."

"Three drops in water every four hours!" ejaculated the patient, in a bewildered manner. "And I'm an aviator!"

—Lippincott's.

Indianapolis Medical Journal (Business Department)

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GASTRO-INTESTINAL DISEASES

are usually more severe and intractable to treatment during the summer months.
Through the prompt use, however, of

Gray's Glycerine Tonic Comp.

and careful regulation of the diet, it is always possible to control in short order, even severe attacks of entero-colitis, summer diarrhea or other bowel affections, and impart to the organism the exact tonic stimulation and recuperative power essential for complete and permanent recovery.

Free from all contraindications of age or season, "Gray's" presents all of the virtues and advantages of cod liver oil, or other tonics—with none of their drawbacks.

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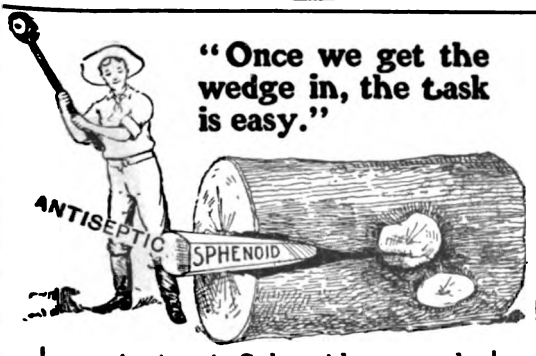

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10 The only contract containing all the above features and which is protection per se. *A sample upon request.*

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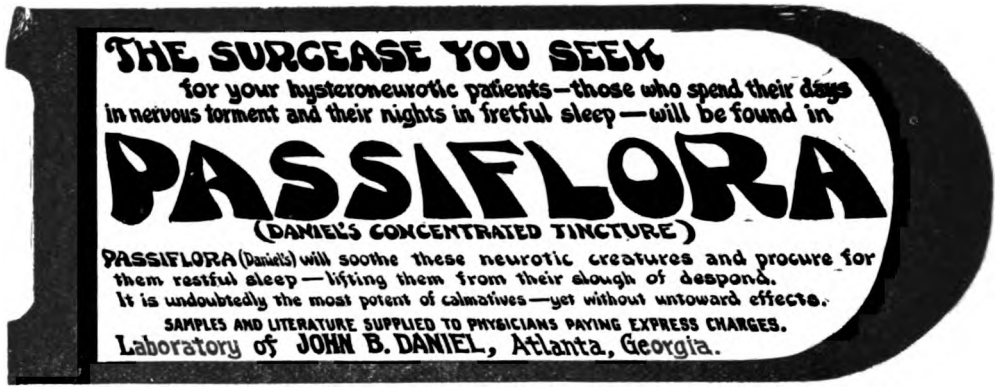

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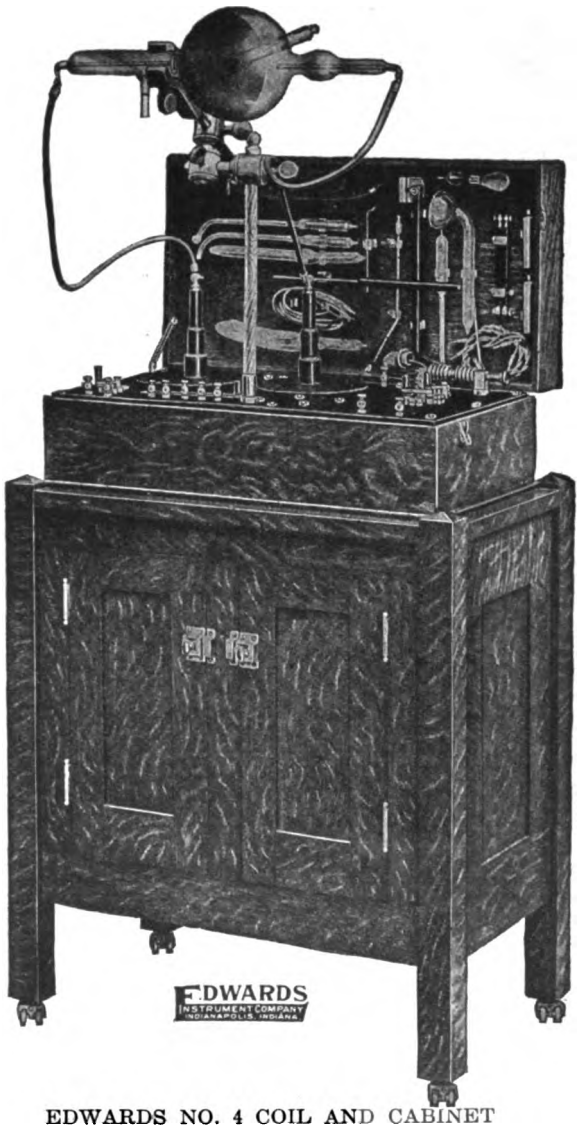

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Physicians who have used SALOFORM are enthusiastic in their praises of its merits.

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Hypnotic, Sedative, Anodyne, Diuretic.

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Syrup Albuminate of Iron with Quinine and Strychnine } HALF PINTS $1.00

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BLOOMINGTON AND INDIANAPOLIS

MATRICULATION

September 21, 1911.

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Graduation from a commissioned high school or its equivalent, plus two years of collegiate work which shall include General Chemistry, Qualitative Analysis and Organic Chemistry, and a preparation in Physics, Biology, and Language.

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Beginning with January 1911, graduation from a commissioned high school, or its equivalent, plus two years of collegiate work. This entrance requirement will be demanded of all candidates for the licensure examination beginning with January, 1915.

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A minimum amount of didactic work.
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In hospitals, 260 beds controlled by school.
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Thirty-six hospital appointments are open to graduates.

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Beginning with session 1909-1910 a fifth year was added to the curriculum, which, until further notice, will be optional and consists of:

A. Graduate work in one of the seven departments of the School of Medicine, or

B. A hospital or dispensary interneship under the following conditions:

1. The hospital or dispensary in which the interneship is served must be approved by the faculty.

2. In addition to the regular duties of an interne, the candidate will be required to prepare a thesis based on an exhaustive study of a selected group of clinical cases involving original work. This work shall be under the immediate supervision of one or more members of the faculty selected by the educational committee.

3. Evidence of thorough clinical work must be presented, the thesis shall be read, and a special examination must be passed, before a committee of the faculty.

On the successful completion of this fifth year, the candidate will be recommended by the faculty for the degree, doctor of medicine, cum laude.

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In entrance requirements, methods of instructions, clinical facilities, instructing staff, and indeed in every detail essential to the most progressive medical school, the Indiana University School of Medicine commends itself to the young men of Indiana who expect to enter on the study of medicine. In addition to the educational advantages available during student life, the graduate finds himself within easy reach of strong corps of sympathetic advisers, particularly helpful during the early years of practice.

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In addition to the regular medical courses referred to above, a combined Arts-Medical course is given, making it possible to secure both the B. S. and M. D. degrees in six years, and the A. B. and M. D. degrees in seven years.

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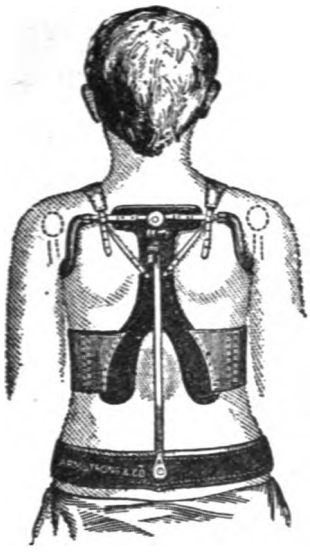

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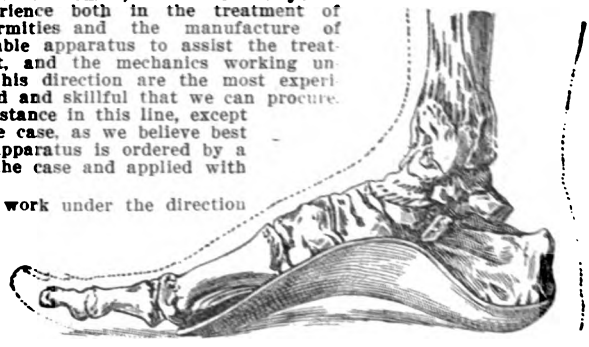

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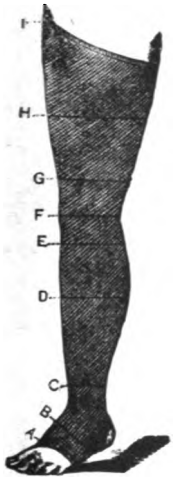

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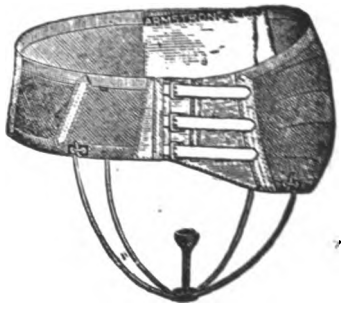

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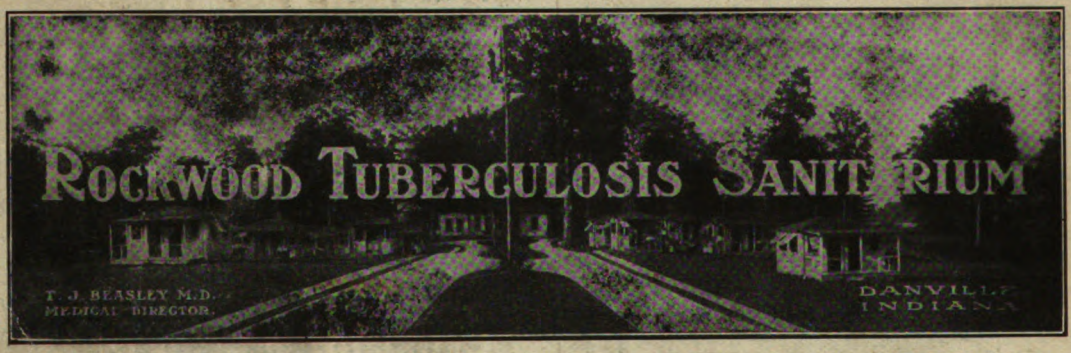

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